LONG-TERM CARE FOR THE ELDERLY IN FLORIDA

HEARING

BEFORE THE

SUBCOMMITTEE ON INVESTIGATIONS AND GENERAL OVERSIGHT

OF THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

NINETY-SEVENTH CONGRESS

SECOND SESSION

ON

EXAMINATION OF THE REGULATIONS GOVERNING NURSING HOMES AND HOW TO IMPROVE THE LONG-TERM CARE OF NURSING HOME RESIDENTS

MARCH 22, 1982

ST. PETERSBURG, FLA.

Printed for the use of the Committee on Labor and Human Resources

U.S. GOVERNMENT PRINTING OFFICE

93-867 O WASHINGTON : 1982

554-43

COMMITTEE ON LABOR AND HUMAN RESOURCES

ORRIN G. HATCH, Utah, *Chairman*

ROBERT T. STAFFORD, Vermont
DAN QUAYLE, Indiana
PAULA HAWKINS, Florida
DON NICKLES, Oklahoma
LOWELL P. WEICKER, JR., Connecticut
GORDON J. HUMPHREY, New Hampshire
JEREMIAH DENTON, Alabama
JOHN P. EAST, North Carolina

EDWARD M. KENNEDY, Massachusetts
JENNINGS RANDOLPH, West Virginia
CLAIBORNE PELL, Rhode Island
THOMAS F. EAGLETON, Missouri
DONALD W. RIEGLE, JR., Michigan
HOWARD M. METZENBAUM, Ohio
SPARK M. MATSUNAGA, Hawaii

GEORGE W. PRITTS, JR., *Chief Counsel*
RENN M. PATCH, *Staff Director and General Counsel*
LAWRENCE C. HOROWITZ, M.D., *Minority Staff Director*

SUBCOMMITTEE ON INVESTIGATIONS AND GENERAL OVERSIGHT

PAULA HAWKINS, Florida, *Chairman*

GORDON J. HUMPHREY, New Hampshire
ORRIN G. HATCH, Utah
(Ex Officio)

EDWARD M. KENNEDY, Massachusetts

JAY C. HOWELL, *Chief Counsel*
WALTER SHERIDAN, *Minority Professional Staff Member*

CONTENTS

CHRONOLOGICAL LIST OF WITNESSES

MONDAY, MARCH 22, 1982

ST. PETERSBURG, FLA.

	Page
Palacin, Liane S., Aging and Adult Services, Department of Health and Rehabilitation Services, Miami, Fla	3
Sutcliffe, Fran, director, Nursing Home Hotline/Patrol, St. Petersburg, Fla	22
Glass, Ethel, task force chairperson, Gray Panthers, Sunrise, Fla	31
Humbles, James L., member, Statewide Long-Term Care Ombudsman Committee, Dowling Park, Fla	35
Palevsky, Elliott, Florida Association of Homes for the Aging, executive director, River Garden Hebrew Home, Jacksonville, Fla	47
Pfeiffer, Eric, M.D., director, Suncoast Gerontology Center, Tampa, Fla	52
Parker, Pamela J., National Citizens' Coalition for Nursing Home Reform, Washington, D.C	98
Haggerty, Virginia, executive director, Florida Nurses Association	122
Vinger, Dr. Irving, associate professor of family medicine, University of Miami School of Medicine, Miami, Fla.; Fred Lane, chairman, Board of Nursing Home Administrators, Deland, Fla.; and Arthur Harris, Florida Health Care Association Administrator, Florida Manor, Orlando, Fla	134

STATEMENTS

Glass, Ethel, task force chairperson, Gray Panthers, Sunrise, Fla	31
Haggerty, Virginia, executive director, Florida Nurses Association	122
Prepared statement	126
Harris, Arthur, administrator, Florida Manor Nursing Home, prepared statement	152
Humbles, James L., member, Statewide Long-Term Care Ombudsman Committee, Dowling Park, Fla	35
Prepared statement	38
Palacin, Liane S., Aging and Adult Services, Department of Health and Rehabilitation Services, Miami, Fla	3
Prepared statement	9
Palevsky, Elliott, Florida Association of Homes for the Aging, executive director, River Garden Hebrew Home, Jacksonville, Fla	47
Parker, Pamela J., National Citizens' Coalition for Nursing Home Reform, Washington, D.C	98
Prepared statement	101
Pfeiffer, Eric, M.D., director, Suncoast Gerontology Center, Tampa, Fla	52
Prepared statement	54
Sutcliffe, Fran, director, Nursing Home Hotline/Patrol, St. Petersburg, Fla	22
Prepared statement	24
Vinger, Dr. Irving, associate professor of family medicine, University of Miami School of Medicine, Miami, Fla.; Fred Lane, chairman, Board of Nursing Home Administrators, Deland, Fla.; and Arthur Harris, Florida Health Care Association Administrator, Florida Manor, Orlando, Fla	134
Prepared statement	137

ADDITIONAL INFORMATION

Articles, publications, etc.: Page

Medical Advances—Schools Begin to Stress Need for Specialists In Treating the Elderly, by Michael Waldholz, from the Wall Street Journal, March 19, 1982 93

Survey of State Agencies: Impact of Federal Policy Changes and Budget Cuts on Nursing Homes, from the National Citizens' Coalition for Nursing Home Reform, March 12, 1982 112

Communications to:

Hawkins, Hon. Paula, a U.S. Senator from the State of Florida, from:

Devall, Donna, chairperson, Social Workers in Long Term Care, Washington, D.C., March 17, 1982 (with attachment) 169

Marshalek, Peggy, president, Washington State Health Activities Volunteer Services, Yakima, Wash., March 19, 1982 (with attachment) 177

Miller, Betty A., executive director, Southern California Health Care, North Hollywood, Calif., March 19, 1982 (with attachment) 172

Perrine, Edward L., executive director, Florida Gulf Health Systems Agency, Inc., Tampa, Fla., March 24, 1982 (with attachments) 180

Tappes, Shelton, chairperson, board of directors, Detroit Area Agency on Aging, Detroit, Mich., April 16, 1982 (with attachments) 186

LONG-TERM CARE FOR THE ELDERLY IN FLORIDA

MONDAY, MARCH 22, 1982

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
SUBCOMMITTEE ON INVESTIGATIONS AND GENERAL OVERSIGHT,
St. Petersburg, Fla.

The subcommittee met at 11:15 a.m., at 175 Fifth Street North, St. Petersburg, Fla., Senator Paula Hawkins (chairman of the subcommittee) presiding.

Present: Senator Hawkins.

Staff present: Terri Kay Parker, staff counsel, and Lisa Demetree, staff investigator.

Senator HAWKINS. Good morning. I apologize for the delay. The runway was closed at Albert Witted Airport when we went to land and they diverted us to another airport.

I am happy to be here with you today. We know we came to the right place to get the right information.

You and I know that societies are judged by the way they treat their elderly citizens. Despite our affluence as a society, we have all been too willing to close our eyes to the realities of life of a large segment of our population, the aged who reside in long-term care institutions.

Nursing homes, in my opinion, should provide the elderly with security, protection, and essential physical, social, and medical needs. I know that some nursing homes provide good care. To the proprietors of those facilities that extend safe and effective care, I say, "Keep up the good work."

Some nursing homes, however, have been referred to as "warehouses" or "dumping grounds" for the dying. They are seen by some medical authorities as being the "hinterland of medicine", the "unwanted stepchild" in the American health care system.

The mere thought of sending a parent or a relative into a nursing home can arouse feelings of guilt and anguish. I do not know that that is necessary. More than 1.3 million Americans currently reside in nursing homes. One out of every four of us will spend some portion of our lives in a long-term care institution. Many of us will die there. Only 10 percent of nursing home residents have a living spouse. More than one-half of them have no close relatives. Sixty percent never receive visitors, and only one out of every five patients will ever return to their homes.

While there are no concrete statistics on the number of aged citizens living in adult care homes, foster homes and welfare hotels, as

they are called, at least another million persons are thought to live in these special residences. These facilities are often located in shabby neighborhoods. They have been called geriatric ghettos. Although recent years have seen significant improvements in the quality of nursing home care, there are still too many reported instances of abuse of the institutionalized elderly in this country. In addition, critical attention is shifting to the urban hotels and boarding homes for the aged. Many reports describe the deplorable conditions found in these homes.

The Federal regulations governing nursing homes are credited for many of the recent improvements. These regulations have been in existence since 1974. They had been under review by the Health-Care Finance Administration of the U.S. Department of Health and Human Services. A task force on regulatory reform has been established to review the standards which nursing homes must meet in order to participate in the medicare and medicaid programs. Their draft proposals, recorded earlier this year indicated an intention to revise regulations concerning social services, patient activities, medical direction, infection control and staff training and development.

I am pleased to report that the Department of Health and Human Services has heeded the concerns expressed by my subcommittee and many of the witnesses who will testify here today. In an 11th hour statement released in Washington on Saturday night, Health and Human Services Secretary Richard Schweiker announced the administration's commitment to maintain the critical Federal regulations protecting patients' safety and health. In his statement, Secretary Schweiker recognized the importance of the regulations, saying that "the current rules have brought about significant improvements in the long-term care of nursing home residents."

I was encouraged by that statement. I was encouraged by the telephone call to my house Saturday afternoon. We had invited the Department to have witnesses here today, and they had declined as late as Thursday of last week. On Saturday, I received a telephone call at my home prior to the release of the press statement informing me that they had decided to retain the regulations as we felt they should. I am encouraged that the importance of the regulations has been recognized by this timely reversal of the administration's position. The announcement even caught the chairman of the task force by surprise.

The status of these Federal regulations and their effect upon the elderly in long-term care institutions, however, remains a key subject of concern for this subcommittee.

Today, we will discuss the role of these regulations as well as the difficulties of recruiting physicians and nurses in nursing homes, the training of aides and orderlies, paperwork requirements, the survey and certification process and other critical areas. This hearing is of vital importance to my subcommittee, to the full committee, and to the full Congress as we review so many items on this short budget list that is before us as Members of the Senate and the Congress.

Today we are very pleased to hear from health care professionals, nursing home administrators, industry representatives and rep-

resentatives of consumer and advocate groups. Some of these witnesses confront on a daily basis the difficulties inherent in providing quality care to residents. The nursing home administrators appearing today have all been successful in providing exemplary care for their residents. I am pleased to be conducting this hearing before so many individuals whose dedicated efforts have helped improve the lives of our elderly.

We are a society oriented to youth—but the fact is that, as a nation, we are aging rapidly. The over 65 age group now totals 22 million people, or about 10 percent of the population of the entire country. Of course, in Florida we know it totals almost 20 percent of the population. When the baby boom generation reaches retirement, this percentage will double. One of every five Americans will be 65 years of age or older. We cannot afford to delay considering important issues in long-term care.

Our first panel of witnesses is patiently seated before us today. I would like to introduce them. Beginning on my left is Ms. Liane Palacin, program supervisor for Adult and Aging Services, the Department of Health and Rehabilitative Services. Seated next to her is Mrs. Fran Sutcliffe, a local celebrity, I might say, and the director of the St. Petersburg Nursing Home Hotline and Nursing Home Patrol. Next to her is Mrs. Ethel Glass, task force chairperson for the Gray Panthers. Finally, on the far right is Mr. James Humbles, a member of the Statewide Long-term Care Ombudsman Committee and administrator of the Advent Christian Village in Dowling Park, Fla.

We thank you all for your patience and for appearing with us today. All of your statements and all of our comments are being taken by the court reporter and will be shared by the full committee back in Washington.

Liane, if you do not mind, I would like to start with you first. I understand you have a short statement and then we will proceed to questions.

STATEMENT OF MS LIANE S. PALACIN, AGING AND ADULT SERVICES, DEPARTMENT OF HEALTH AND REHABILITATION SERVICES, MIAMI, FLA.

Ms. PALACIN. Thank you, Senator Hawkins, for inviting me. I am here representing the HRS aging and adult services program in District 11, which serves Dade and Monroe Counties. I appreciate the opportunity to appear before you to participate in this discussion on long-term care for the elderly in Florida.

The adult congregate living facility program, better known as the ACLF program, which is a part of long-term care, was created as a part of the continuum of community care for the elderly and an alternative to institutionalization.

I shall now provide you with an overview of the program itself in District 11, which serves Dade and Monroe Counties.

As a part of an ongoing effort to provide the best possible services to those in need of long-term care, HRS established a pilot project in Dade County during 1981. The project unifies preadmission screening, level of care determination, placement and payment to nursing homes together with licensure and certification respon-

sibilities for ACLF's adult foster homes, adult day care centers, and nursing homes. It is under one administrator in order to insure continuity and better coordination.

This long-term care project has worked closely with my program office, aging and adult services, and with the district long-term care ombudsman committee, a community-based group of volunteers appointed by the Governor to investigate complaints and identify problems in the aforementioned types of facilities. The project has concentrated its efforts in recent months on improving the regulations of ACLF's in Dade County. These are nonmedical facilities which provide room and board with personal care. They are different from boarding homes because of the personal care such as assistance with bathing, ambulation, and supervision of self-administered medications. They are different from nursing homes in that no nursing or bed care is provided.

Last summer the project staff began a concentrated effort toward identifying any existing deficiencies in ACLF's and found problems ranging from nonexistent record keeping to poor resident care standards. They directed that corrective action be taken to be sure that each facility attained compliance with the established minimum standards. Furthermore, attempts were made to identify clandestine facilities for the purpose of either closing or bringing them into compliance.

The project also developed initiatives in the areas of proposed legislation rules and policy development, sanctions, training and personal consultation with ACLF operators and public educators. As a result of these actions, the following has occurred:

One, 29 facilities have been fined a total of $29,125.

Two, 17 clandestine ACLF operations have been identified and either brought into compliance or closed.

Three, 26 applications for licenses have been denied pending compliance with State standards.

Four, 13 injunctive actions have been taken.

Five, two facilities have been placed under receivership.

Six, four training sessions have been held to assist operators to understand State requirements and recommend appropriate educational courses.

Seven, individual consultations have been provided to all operators to help improve operations.

In spite of these aggressive efforts, unlicensed ACLF's may still exist in the community. It is unlawful to operate without a license. HRS intends to use all of the available sanctions of the law to deter individuals from entering into or continuing such practices. These sanctions are considerable and extensive and include injunctions, receiverships, and referral for criminal action. Public knowledge of the action already taken by HRS should help serve as a deterrent against further violations of the law.

The major problems that I would like to focus on in this area concerning the ACLF Act are as follows:

One, ACLF's offer a great range of services to a large number of residents who require varying service needs. The law needs to be more specific in the levels of care to be licensed. Since residents' needs vary considerably, as an example, single staffing standards

to meet needs of residents receiving minimal or no supervision to those receiving 24 hours of supervision.

Two, development of more stringent standards for ACLF administrators.

Three, establish an interstate registry for informational exchange on ACFL operators. This would be accomplished by agreements through the States.

Four, establish an intrastate registry for informational exchange on ACLF operations.

Five, consideration should be given to making it a criminal offense for those people who knowingly refer persons to illegal ACLF operations.

Six, establish at the Federal level a centralized fingerprint and photograph identification section for those ACLF operators who have or are suspected of operating facilities in other States.

Seven, the problem of zoning for all types of group homes needs to be urgently addressed. Local zoning ordinances have made it increasingly difficult for ACLF's to remain in business. These facilities provide a vital residential setting for over 20,000 Floridians. It must be remembered that there are very few alternatives. Local communities do not always welcome an ACLF. In fact, they are often successful in zoning them out of neighborhoods.

I have received calls from neighbors bothered by "these people." One person went so far as to say he preferred having a red light district than an ACLF in his neighborhood. Because of this attitude, it is not surprising to find that low income elderly are often relegated to the poor decaying sections of the community where rooms are cheaper, service quality inadequate, crime rate high and operators unqualified, unfeeling, and unscrupulous.

If all of these areas had been covered, then perhaps the Cora Galvin incident would not have taken place. The main recurring characteristic which the 39 disappeared elderly had in common is they all lived on a fixed income. Due to fear and loneliness these elderly turned to Lucille Walker, Galvin's real name, for comfort and protection. She appears to be a likable person, dispensing small doses of love to the elderly who felt—or really were—unloved and telling them things which they wanted to hear. She apparently took people into her many homes in Florida and Detroit. Following this, their social security checks, bank accounts, and assets were unable to be accounted for. Then, finally, the residents themselves started disappearing, but it was some time later before anyone noticed these events.

It is my understanding that the list of missing people grew to 39. Of these, 32 have appeared, some suffering from malnutrition and emotional stress. Investigators report the possibility that a few might have lost thousands of dollars.

In 1977, in Miami, Lucille Collins' ACLF—that is another one of her aliases, was closed by HRS due to the strange circumstances of a resident's death. She disappeared leaving a bench warrant for her arrest.

In October 1980, using her mother's name, Cora Galvin, also one of her many aliases, she obtained an ACLF license to operate a home in Dade County, Tangelia.

County and hospital social workers referred their elderly to Tangelia. These residents were not on public assistance; therefore, did not have an HRS social worker. The following series of unconnected events brought to light the illegal activities of Cora Galvin.

Another ACLF, not connected with Galvin, was cited for violations and closed. Although none of the residents were HRS clients, we were responsible in assisting them and their families with the move to other facilities. One of these residents was 91-year-old Kathy Klaasen. During the followup to placement in Tangelia, the HRS social worker began monitoring and checking Klaasen's financial affairs. She noticed that two bank accounts totaling $20,000 had been closed within a 2-month period after placement in Tangelia.

Following our instructions, the social worker contacted and alerted the bank to the unusual circumstances. Additional attempts were made to withdraw other amounts, but these were unsuccessful due to our alerting of the bank officials.

Seeing that Mrs. Klaasen had periods of lucidity and irrational behavior and believing her to be in need of protection, I instructed her social worker to initiate guardianship proceedings. On August 4, a guardian was named by the court. Said guardian went to Tangelia the next day, August 5, seeking Mrs. Klaasen to be told that she had left, signing herself out to destination unknown—91 years old. Her roommate, Grace Chamberlain, 63 years old, had also signed herself out, but she was driving alone in her car to an unknown destination in New Jersey. The signout statements—I have seen them—for both women supposedly are in Galvin's writing. The signatures are Klaasen's and Chamberlain's.

HRS immediately reported the two women missing, removed and relocated the other residents and closed Tangelia. It must be noted that all efforts to locate Cora Galvin were unsuccessful. She had disappeared.

Before the guardianship proceedings had been initiated, the social worker and myself had received very strange phone calls saying that they were friends and relatives of Mrs. Klaasen and "they" were going to provide a home for her, take care of her, and came for her.

Mrs. Klaasen's only living relative is an elderly sister residing in New York whom she has not seen for over 20 years. I myself verified this by speaking with her.

After the disappearances, other anonymous phone calls informed us that Cora Galvin had been killed in auto accidents ranging from Boston to Los Angeles. I also checked these reports out with the local law enforcement agencies and morgues. No accidents had occurred or been reported involving a Cora Galvin.

Immediately afterward, my office started receiving inquiries from various hospitals, the county welfare department, community agencies, friends, and relatives regarding the whereabouts of other residents who had been referred to Tangelia. These names were not among the people we had moved.

The number grew from two to nine. Two of the nine were subsequently found in an illegal Galvin home, thanks to the tip of a concerned citizen. But Kathy Klaasen, Grace Chamberlain, Lillian

Meisner, Felicia Benateav, Marian Rumsford, Edna Thompson, and Donald Hill were still unaccounted for.

At 1:27 a.m., on August 13, 1981, five elderly women approached the nurses' station at Detroit Receiving Hospital and said they wanted to buy airplane tickets to Florida. Five of our ladies had appeared. They had been flown to Detroit on August 1 after being told they were going on a picnic. They were put in a cellar with water seepage of approximately an inch in depth. Mushrooms and fungus were growing on the edges of the room. They were made to sleep on four damp mattresses and were provided with three flimsy sheets for covering. They were smart. They kept their clothes on. If not, they would have frozen. They were cold, hungry and frightened, not knowing what was going to happen to them next.

I have seen pictures of their living conditions. It is a miracle they did not die. Not even in a horror film have I ever seen such terrible and subhuman conditions. The women were permitted to leave this dungeon only at mealtime. They were herded upstairs, hurried through a sparse meal and then again returned to their damp and dark, windowless prison.

On August 13, the women were awakened and taken to the hospital. They were told to ask for the tickets that they, the people who had left them there, would return with their luggage. The rest is history.

On August 20, Detroit officials found four more Florida residents, one of them suffering from malnutrition and lesions on his lungs.

On August 26, four more people from Miami were found sleeping in a cement basement on three mattresses and a coffee table. They informed that they were among seven brought from Miami 3 weeks previously. A 63-year-old woman was hospitalized from exhaustion and malnutrition. It appeared that during this trip an elderly man died of a heart attack. His body was left in some town in Georgia.

On August 28, 10 more persons were found in another home in Detroit. It was described as a hovel, four mattresses in a bare stifling attic, one filthy bathroom for all. The house was deserted with practically no food. The 10 had been there since June. Most were suffering from malnutrition and emotional disorders. Some had to be carried out and hospitalized. They also had been brought to Detroit in a van.

The list of charges in Detroit against Cora Galvin is long, very long. The main one is kidnaping. It is shocking and frightening that anyone practicing such inhumanity and cruelty could go undetected for such a long time. Even more frightening is the thought, who knows how long, and how widespread these abuses against the elderly had been taking place.

Again and again everyone who has had dealings with the elderly in this case have asked them why they remained with Galvin. Some answered they feared her unspoken or spoken threats of institutionalization or being placed in nursing homes or a mental hospital. Others were seeking a haven from crime-ridden neighborhoods. Some had no money to get out from under. Then a few were just simply grateful for the interest, any interest shown to them.

In closing, we are all aware that there are problems. Some, unfortunately, related to this ACLF program, but these problems cannot be solely addressed by additional financial support, new

policies, changes in regulations, and changes in the law. Our community, like all others in this Nation, must come to grips with the fact that "these people" are not someone else's elderly, they are ours. They are us. The total community must assume responsibility for helping to protect the quality of their lives. It is their right. They have earned it. Let us not fail them.

Thank you.

[The prepared statement of Ms. Palacin follows:]

PRESENTATION

SENATE SUBCOMMITTEE ON INVESTIGATION AND GENERAL OVERSIGHT

LONG TERM CARE FOR THE ELDERLY IN FLORIDA

MARCH 22, 1982

LIANE S. PALACIN

PROGRAM SUPERVISOR

STATE OF FLORIDA DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

AGING AND ADULT SERVICES

DISTRICT XI

SENATOR HAWKINS, MEMBERS OF THE LABOR AND HUMAN RESOURCES INVESTIGATION AND OVERSIGHT COMMITTEE.

I AM LIANE PALACIN, HRS AGING AND ADULT SERVICES PROGRAM SUPERVISOR IN DISTRICT XI, SERVING DADE AND MONROE COUNTIES. I APPRECIATE THE OPPORTUNITY TO APPEAR BEFORE YOU TO PARTICIPATE IN A DISCUSSION ON LONG TERM CARE FOR THE ELDERLY IN FLORIDA.

THE ADULT CONGREGATE LIVING FACILITY PROGRAM, BETTER KNOWN AS ACLF, WAS CREATED AS PART OF THE CONTINUUM OF COMMUNITY CARE FOR THE ELDERLY--AN ALTERNATIVE TO INSTITUTIONALIZATION. I SHALL NOW PROVIDE YOU WITH AN OVERVIEW OF THE PROGRAM IN DISTRICT XI.

AS A PART OF AN ONGOING EFFORT TO PROVIDE THE BEST POSSIBLE SERVICES TO THOSE IN NEED OF LONG-TERM CARE, HRS ESTABLISHED A PILOT PROJECT IN DADE COUNTY DURING 1981. THE PROJECT UNIFIES PRE-ADMISSION SCREENING, LEVEL OF CARE DETERMINATION, PLACEMENT AND PAYMENTS TO NURSING HOMES TOGETHER WITH LICENSURE AND CERTIFICATION RESPONSIBILITIES FOR ACLFs, ADULT FOSTER HOMES, ADULT DAY CARE CENTERS, AND NURSING HOMES UNDER ONE ADMINISTRATOR IN ORDER TO ENSURE CONTINUITY AND BETTER COORDINATION. THIS LONG-TERM CARE PROJECT HAS WORKED CLOSELY WITH MY

OFFICE; AGING AND ADULT SERVICES, AND THE DISTRICT LONG-TERM CARE OMBUDSMAN COMMITTEE, A COMMUNITY-BASED GROUP OF VOLUNTEERS, APPOINTED BY THE GOVERNOR, TO INVESTIGATE COMPLAINTS AND IDENTIFY PROBLEMS IN THE FOUR AFOREMENTIONED TYPES OF FACILITIES. THE PROJECT HAS CONCENTRATED IT'S EFFORTS IN RECENT MONTHS ON IMPROVING THE REGULATIONS OF ACLFs IN DADE COUNTY. THESE ARE NON-MEDICAL FACILITIES WHICH PROVIDE ROOM AND BOARD WITH PERSONAL CARE. THEY ARE DIFFERENT FROM BOARDING HOMES BECAUSE OF THE PERSONAL CARE SUCH AS ASSISTANCE WITH BATHING, AMBULATING, AND SUPERVISION OF SELF-ADMINISTERED MEDICATIONS. THEY ARE DIFFERENT FROM NURSING HOMES IN THAT NO NURSING OR BED CARE IS PROVIDED.

LAST SUMMER, THE PROJECT'S STAFF BEGAN A CONCENTRATED EFFORT TOWARD IDENTIFYING ANY EXISTING DEFICIENCIES IN ACLFs, AND FOUND PROBLEMS RANGING FROM NON-EXISTENT RECORD-KEEPING TO POOR RESIDENT CARE STANDARDS. THEY DIRECTED THAT CORRECTIVE ACTION BE TAKEN TO ENSURE THAT EACH FACILITY ATTAIN COMPLIANCE WITH ESTABLISHED MINIMUM STANDARDS. FURTHERMORE, ATTEMPTS WERE MADE TO IDENTIFY CLANDESTINE FACILITIES FOR THE PURPOSE OF EITHER CLOSING OR BRINGING THEM INTO COMPLIANCE.

THE PROJECT ALSO DEVELOPED INITIATIVES IN THE AREAS OF PROPOSED LEGISLATION, RULES AND POLICY DEVELOPMENT, SANCTIONS, TRAINING AND PERSONAL

CONSULTATIONS WITH ACLF OPERATORS AND PUBLIC EDUCATION. AS A RESULT OF THESE ACTIONS, THE FOLLOWING HAS OCCURRED:

1. 29 FACILITIES HAVE BEEN FINED, TOTALING $29,125.
2. 17 CLANDESTINE ACLF OPERATIONS HAVE BEEN IDENTIFIED AND EITHER BROUGHT INTO COMPLIANCE OR CLOSED.
3. 26 APPLICATIONS FOR LICENSES HAVE BEEN DENIED PENDING COMPLIANCE WITH STATE STANDARDS.
4. 13 INJUNCTIVE ACTIONS HAVE BEEN TAKEN.
5. 2 FACILITIES HAVE BEEN PLACED UNDER RECEIVERSHIP.
6. 4 TRAINING SESSIONS HAVE BEEN HELD TO ASSIST OPERATORS TO UNDERSTAND STATE REQUIREMENTS AND RECOMMEND OTHER APPROPRIATE EDUCATIONAL COURSES.
7. INDIVIDUAL CONSULTATIONS HAVE BEEN PROVIDED TO ALL OPERATORS TO HELP IMPROVE OPERATIONS.

IN SPITE OF THESE AGGRESSIVE EFFORTS, UNLICENSED ACLFs MAY STILL EXIST IN THE COMMUNITY. IT IS UNLAWFUL TO OPERATE WITHOUT A LICENSE. HRS INTENDS TO USE ALL THE AVAILABLE SANCTIONS OF THE LAW TO DETER INDIVIDUALS FROM ENTERING INTO OR CONTINUING SUCH PRACTICES. THESE SANCTIONS ARE CONSIDERABLE AND EXTENSIVE AND INCLUDE INJUNCTIONS, RECEIVERSHIP AND REFERRAL FOR CRIMINAL ACTION. PUBLIC KNOWLEDGE OF THE ACTION ALREADY TAKEN BY HRS SHOULD HELP SERVE AS A DETERRENT AGAINST FURTHER VIOLATIONS OF THE LAW.

THE MAJOR PROBLEMS, THAT I WOULD LIKE TO FOCUS ON, CONCERNING THE ACLF ACT ARE AS FOLLOWS:

1. ACLFs OFFER A GREAT RANGE OF SERVICES TO A LARGE NUMBER OF RESIDENTS WHO REQUIRE VARYING SERVICE NEEDS. THE LAW NEEDS TO BE MORE SPECIFIC IN THE LEVELS OF CARE TO BE LICENSED, SINCE RESIDENTS NEEDS VARY CONSIDERABLY. AS AN EXAMPLE, SINGLE STAFFING STANDARDS TO MEET NEEDS OF RESIDENTS RECEIVING MINIMAL OR NO SUPERVISION TO THOSE RECEIVING 24 HOUR SUPERVISION.

2. DEVELOPMENT OF MORE STRINGENT STANDARDS FOR ACLF ADMINISTRATORS.

3. ESTABLISH AN INTER-STATE REGISTRY FOR INFORMATIONAL EXCHANGE ON ACLF OPERATORS, THIS WOULD BE ACCOMPLISHED BY AGREEMENT BETWEEN STATES.

4. ESTABLISH AN INTRA-STATE REGISTRY FOR INFORMATIONAL EXCHANGE ON ACLF OPERATIONS.

5. CONSIDERATION SHOULD BE GIVEN TO MAKING IT A CRIMINAL OFFENSE FOR THOSE PEOPLE WHO KNOWINGLY REFER PERSONS TO ILLEGAL ACLF OPERATIONS.

6. ESTABLISH, AT THE FEDERAL LEVEL, A CENTRALIZED FINGERPRINT AND PHOTOGRAPH IDENTIFICATION SECTION FOR THOSE ACLF OPERATORS WHO HAVE OR ARE SUSPECTED OF OPERATING FACILITIES IN OTHER STATES.

7. THE PROBLEM OF ZONING FOR ALL TYPES OF GROUP HOMES NEEDS TO BE ADDRESSED. LOCAL ZONING ORDINANCES HAVE MADE IT INCREASINGLY DIFFICULT FOR ACLFs TO REMAIN IN BUSINESS. THESE FACILITIES PROVIDE A VITAL RESIDENTIAL SETTING FOR OVER 20,000 FLORIDIANS. IT MUST BE REMEMBERED THEY HAVE NO OTHER ALTERNATIVE.

93-587 O—82——2

LOCAL COMMUNITIES DO NOT ALWAYS WELCOME ACLFs AND, IN FACT, ARE OFTEN SUCCESSFUL IN ZONING THEM OUT OF NEIGHBORHOODS. I RECEIVE CALLS FROM NEIGHBORS BOTHERED BY "THESE PEOPLE". ONE PERSON WENT SO FAR AS TO SAY THAT HE PREFERRED HAVING A RED LIGHT DISTRICT THAN AN ACLF IN HIS NEIGHBORHOOD. BECAUSE OF THIS ATTITUDE, IT ISN'T SURPRISING TO FIND THAT LOW INCOME ELDERLY ARE OFTEN RELEGATED TO THE POORER, DECAYING SECTIONS OF THE COMMUNITY WHERE ROOMS ARE CHEAPER, SERVICE QUALITY INADEQUATE, CRIME RATES HIGH, AND OPERATORS UNQUALIFIED, UNFEELING AND UNSCRUPULOUS.

IF ALL THESE AREAS HAD BEEN COVERED THEN PERHAPS THE CORA GALVIN INCIDENT WOULD NOT HAVE TAKEN PLACE.

THE MAIN RECURRING CHARACTERISTIC WHICH THE 39 DISAPPEARED ELDERLY HAD IN COMMON IS -- THEY ALL LIVED ON A FIXED INCOME.

DUE TO FEAR AND LONLINESS, THESE ELDERLY TURNED TO LUCILLE WALKER, (GALVIN'S REAL NAME), FOR COMFORT AND PROTECTION.

SHE APPEARS TO BE A LIKEABLE PERSON, DISPENSING SMALL DOSES OF "LOVE"

TO ELDERLY WHO FELT OR REALLY WERE UNLOVED AND TELLING THEM THE THINGS WHICH THEY WANTED TO HEAR. SHE APPARENTLY TOOK PEOPLE INTO HER MANY HOMES IN FLORIDA AND DETROIT; FOLLOWING THIS THEIR SOCIAL SECURITY CHECKS, BANK ACCOUNTS AND ASSETS WERE UNABLE TO BE ACCOUNTED FOR; THEN FINALLY, THE RESIDENTS, THEMSELVES, STARTED DISAPPEARING. BUT IT WAS SOME TIME LATER BEFORE ANYONE NOTICED THESE EVENTS. IT IS MY UNDERSTANDING THAT THE LIST OF MISSING PEOPLE GREW TO 39 -- OF THESE, 32 HAVE APPEARED, MANY SUFFERING FROM MALNUTRITION AND EMOTIONAL STRESS. INVESTIGATORS REPORT THE POSSIBILITY THAT A FEW MIGHT HAVE LOST THOUSANDS OF DOLLARS.

IN 1977 LUCILLE COLLINS' ACLF (AKA C. GALVIN), WAS CLOSED BY HRS DUE TO THE STRANGE CIRCUMSTANCES OF A RESIDENT'S DEATH. SHE DISAPPEARED LEAVING A BENCH WARRENT FOR HER ARREST. IN OCTOBER 1980, USING HER MOTHER'S NAME CORA GALVIN, ONE OF HER MANY ALIASES, SHE OBTAINED AN ACLF LICENSE TO OPERATE A HOME IN DADE COUNTY --TANGELIA. COUNTY AND HOSPITAL SOCIAL WORKERS REFERRED THEIR ELDERLY TO TANGELIA. THESE RESIDENTS WERE NOT ON PUBLIC ASSISTANCE, THEREFORE, DID NOT HAVE AN HRS SOCIAL WORKER. THE FOLLOWING SERIES OF UNCONNECTED EVENTS BROUGHT TO LIGHT THE ILLEGAL ACTIVITIES OF CORA GALVIN.

ANOTHER ACLF, NOT CONNECTED WITH GALVIN, WAS CITED FOR VIOLATIONS AND CLOSED. ALTHOUGH NONE OF THE RESIDENTS WERE HRS CLIENTS WE WERE RESPONSIBLE IN ASSISTING THEM AND THEIR FAMILIES WITH THE MOVE TO OTHER FACILITIES. ONE OF THESE RESIDENTS WAS 91 YEAR OLD KATHE KLASSEN. DURING THE FOLLOW-UP TO PLACEMENT TO TANGELIA, THE HRS SOCIAL WORKER, MS. VIDANA, BEGAN MONITORING/CHECKING KLASSEN'S FINANCIAL AFFAIRS, NOTIFIED THAT 2 BANK ACCOUNTS TOTALING $20,000, HAD BEEN CLOSED WITHIN A 2 MONTH PERIOD AFTER PLACEMENT AT TANGELIA. FOLLOWING OUR INSTRUCTIONS, THE SOCIAL WORKER CONTACTED AND ALERTED THE BANKS TO THE UNUSUAL CIRCUMSTANCES.

ADDITIONAL ATTEMPTS WERE MADE TO WITHDRAW OTHER AMOUNTS BUT THESE WERE UNSUCCESSFUL DUE TO ALERTED BANK OFFICIALS. SEEING THAT MS. KLASSEN HAD PERIODS OF LUCIDITY TO IRRATIONAL BEHAVIOR AND BELIEVING HER TO BE IN NEED OF PROTECTION, I INSTRUCTED OUR SOCIAL WORKER TO INITIATE GUARDIANSHIP PROCEEDINGS. ON AUGUST 4 A GUARDIAN WAS NAMED BY THE COURT, SAID GUARDIAN WENT TO TANGELIA THE NEXT DAY, AUGUST 5, SEEKING MS. KLASSEN TO BE TOLD THAT SHE HAD LEFT, SIGNING HERSELF OUT TO DESTINATION UNKNOWN. HER ROOMMATE, GRACE CHAMBERLAIN, HAD ALSO SIGNED HERSELF OUT, BUT SHE WAS DRIVING, ALONE IN HER CAR, TO AN UNKNOWN DESTINATION IN

-/-

NEW JERSEY! THE SIGN OUT STATEMENTS FOR BOTH WOMEN ARE, SUPPOSEDLY IN GALVIN'S WRITING, THE SIGNATURES ARE KLASSEN'S AND CHAMBERLAIN'S. HRS IMMEDIATELY REPORTED THE 2 WOMEN AS MISSING, REMOVED AND PLACED THE RESIDENTS, AND CLOSED TANGELIA. IT MUST BE NOTED THAT ALL EFFORTS TO LOCATE GALVIN WERE UNSUCCESSFUL. BEFORE THE GUARDIANSHIP PROCEEDINGS WERE INITIATED MS. VIDANA AND MYSELF HAD RECEIVED VARIOUS STRANGE PHONE CALLS, SAYING THAT THEY WERE FRIENDS/RELATIVES OF MS. KLASSEN, THEY WERE GOING TO PROVIDE A HOME FOR HER, TAKE CARE OF HER. MS. KLASSEN'S ONLY LIVING RELATIVE IS AN ELDERLY SISTER RESIDING IN NEW YORK, WHOM SHE HASN'T SEEN FOR OVER 20 YEARS. I MYSELF VERIFIED THIS BY SPEAKING WITH HER. AFTER TH DISAPPEARANCES, OTHER ANONYMOUS PHONE CALLS INFORMED THAT CORA GALVIN HAD BEEN KILLED IN AUTO ACCIDENTS RANGING FROM BOSTON TO LOS ANGELES. I ALSO CHECKED THESE REPORTS OUT WITH THE LOCAL LAW ENFORCEMENT AGENCIES AND MORGUES. NO ACCIDENTS HAD OCCURRED/BEEN REPORTED INVOLVING A CORA GALVIN. IMMEDIATELY AFTERWARD, MY OFFICE STARTED RECEIVING INQUIRIES FROM VARIOUS HOSPITALS, COUNTY WELFARE DEPARTMENT, COMMUNITY AGENCIES, FRIENDS AND RELATIVES REGARDING THE WHEREABOUTS OF OTHER RESIDENTS WHO HAD BEEN RE-FERRED TO TANGELIA. THESE NAMES WERE NOT AMONG THE PEOPLE MOVED. THE NUMBER GREW FROM 2 TO 9. TWO OF THE NINE WERE SUBSEQUENTLY FOUND

IN AN ILLEGAL GALVIN HOME, THANKS TO THE TIP OF A CONCERNED CITIZEN. BUT KATHL KLASSEN, GRACE CHAMBERLAIN, LILLIAN MEIZNER, FELICIA RENATEAU, MIRIAM RUMSFORD, EDNA THOMAS AND DONALD HILL WERE STILL UNACCOUNTED FOR. AT 1:27 AM ON AUGUST 13, 1981, 5 ELDERLY WOMEN APPROACHED THE NURSE'S STATION AT DETROIT RECEIVING HOSPITAL AND SAID THEY WANTED TO BUY AIR-PLANE TICKETS TO FLORIDA; 5 OF THE LADIES HAD APPEARED. THEY HAD BEEN FLOWN TO DETROIT ON AUGUST 1ST AFTER BEING TOLD THEY WERE GOING ON A PICNIC! THEY WERE PUT IN A CELLER WITH WATER SEEPAGE OF APPROXIMATELY 1 INCH IN DEPTH (MUSHROOMS AND FUNGUS WERE GROWING ON THE EDGES OF THE ROOM); THEY WERE MADE TO SLEEP ON 4 DAMP MATTRESSES, AND WERE PROVIDED WITH 3 FLIMSY SHEETS FOR COVERING. THEY WERE SMART, THEY KEPT THEIR CLOTHING ON. IF NOT, THEY WOULD HAVE FROZEN. THEY WERE COLD, HUNGRY AND FRIGHTENED, NOT KNOWING WHAT WAS GOING TO HAPPEN TO THEM.

I HAVE SEEN PICTURES OF THEIR LIVING CONDITIONS, IT IS A MIRACLE THEY DIDN'T DIE -- FOR NOT EVEN IN A HORROR FILM HAVE I EVER SEEN SUCH TERRIBLE AND SUB-HUMAN CONDITIONS. THE WOMEN WERE PERMITTED TO LEAVE THIS DUNGEON ONLY AT MEALTIME. THEY WERE HERDED UPSTAIRS, HURRIED THROUGH A SPARSE MEAL THEN AGAIN RETURNED TO THEIR DAMP AND DARK WIN-DOWLESS PRISON.

ON AUGUST 13 THE WOMEN WERE AWAKENED AND TAKEN TO THE HOSPITAL. THEY

WERE TOLD TO ASK FOR TICKETS THAT "THEY" WOULD RETURN WITH THEIR LUGGAGE. THE REST IS HISTORY.

ON AUGUST 20TH DETROIT OFFICIALS FOUND 4 MORE FLORIDA RESIDENTS; ONE OF THEM SUFFERING FROM MALNUTRITION AND LESIONS ON HIS LUNGS.

ON AUGUST 26, 4 MORE PEOPLE FROM MIAMI WERE FOUND SLEEPING IN A CEMENT BASEMENT ON 3 MATTRESSES AND A COFFEE TABLE. THEY INFORMED THAT THEY WERE AMONG 7 BROUGHT FROM MIAMI 3 WEEKS EARLIER. A 65 YEAR OLD WOMAN WAS HOSPITALIZED FOR EXHAUSTION AND MALNUTRITION. IT APPEARS DURING THIS TRIP AN ELDERLY MAN DIED OF A HEART ATTACK, HIS BODY WAS LEFT IN A TOWN IN GEORGIA.

ON AUGUST 28, 10 MORE PERSONS WERE FOUND IN ANOTHER HOME IN DETROIT. IT WAS DESCRIBED AS A HOVEL, MATTRESSES IN A BARE STIFLING ATTIC, ONE FILTHY BATHROOM FOR ALL. THE HOUSE WAS DESERTED WITH PRACTICALLY NO FOOD. THE 10 HAD BEEN THERE SINCE JUNE. MOST WERE SUFFERING FROM MALNUTRITION AND EMOTIONAL DISORDERS; SOME HAD TO BE CARRIED OUT AND HOSPITALIZED. THEY ALSO HAD BEEN BROUGHT TO DETROIT IN A VAN. THE LIST OF CHARGES IN DETROIT AGAINST CORA GALVIN IS LONG, THE MAIN ONE OF THEM IS KIDNAPPING. IT IS SHOCKING AND FRIGHTENING THAT ANYONE PRACTICING SUCH INHUMANITY AND CRUELTY COULD GO UNDETECTED FOR SUCH A LONG PERIOD OF TIME. EVEN MORE FRIGHTENING IS THE THOUGHT - WHO KNOWS HOW LONG AND WIDESPREAD THESE ABUSES AGAINST THE

ELDERLY HAVE BEEN TAKING PLACE. AGAIN AND AGAIN ANYONE WHO HAS HAD DEALINGS WITH THE ELDERLY IN THIS CASE HAVE ASKED THEM WHY THEY REMAINED WITH GALVIN. SOME ANSWERED THEY FEARED HER UNSPOKEN OR SPOKEN THREAT OF INSTITUTIONALIZATION OF BEING PLACED IN A NURSING HOME OR A MENTAL HOSPITAL. OTHERS WERE SEEKING A "HAVEN" FROM CRIME-RIDDEN NEIGHBORHOODS, SOME HAD NO MONEY TO GET OUT FROM UNDER, AND THEN A FEW WERE SIMPLY GRATEFUL FOR THE INTEREST -- ANY INTEREST SHOWN TO THEM.

IN CLOSING, WE ARE ALL AWARE THAT THERE ARE PROBLEMS, SOME UNFORTUNATELY RELATED TO THE ACLF PROGRAM BUT THESE PROBLEMS CANNOT BE SOLELY ADDRESSED BY ADDITIONAL FINANCIAL SUPPORT, NEW POLICIES, CHANGES IN REGULATIONS, THE LAW. OUR COMMUNITIES, LIKE ALL OTHERS IN THE NATION, MUST COME TO GRIPS WITH THE FACT THAT "THESE PEOPLE" ARE NOT SOMEONE ELSE'S ELDERLY BUT THEY ARE OURS -- THEY ARE US -- AND THE TOTAL COMMUNITY MUST ASSUME THE RESPONSIBILITY FOR HELPING TO PROTECT THE QUALITY OF THEIR LIVES. IT IS THEIR RIGHT...THEY HAVE EARNED IT. LET US NOT FAIL THEM.

Senator HAWKINS. Thank you, Liane, that was a very moving statement and causes us to pause and think a great deal about the problems facing us.

Can you give an estimate of how many unlicensed ACLF's there are in Monroe County and Dade County?

Ms. PALACIN. No, I cannot. It is very difficult unless somebody calls in or we find out at times through an advertisement or the emergency squad or a policeman, but it is very difficult to know the whereabouts of these unlicensed facilities due to their illegality.

Senator HAWKINS. What is the average number of residents in an adult care——

Ms. PALACIN. More or less 30, from 25 to 30.

Senator HAWKINS. Thirty?

Ms. PALACIN. Yes. That would be a good operation.

Senator HAWKINS. Are any of them physically or mentally disabled?

Ms. PALACIN. Yes. In Dade County, we have some ACLF's, quite a few, who mix the mental health, the emotionally disturbed clients with the elderly.

Senator HAWKINS. Do the ACLF operators receive any specific training?

Ms. PALACIN. We have provided minimum training for them in the district. In how to deal with the different types of elderly and in understanding the aging process.

Senator HAWKINS. The Cora Galvin story, of course, is horrifying to all of us. How did the authorities finally apprehend Cora Glavin?

Ms. PALACIN. According to the newspapers, I believe she was apprehended in Arizona, She was using——

Senator HAWKINS. Arizona, you say?

Ms. PALACIN. Arizona. She was using another alias. During this period of her disappearance, she was taking care of an elderly gentleman, a widower. She was using that widower's wife's name and social security number. In other words, that social security number and that name was that man's wife—she had been dead for some time, for over a year.

Senator HAWKINS. She was using her identity?

Ms. PALACIN. Yes.

Senator HAWKINS. She was apprehended in Arizona, you say?

Ms. PALACIN. Yes, I believe it was Arizona.

Senator HAWKINS. I believe you also said that of the 39 residents there are still 7 unaccounted for?

Ms. PALACIN. Yes. Most of the names of those persons came from Detroit, but two of those names, Edna Thomas and Donald Hill, are definitely from Miami.

In other words, there was an agency that called us that they had placed these two people in Tangelia. The other names are from the Detroit law enforcement agency. Obviously, they disappeared from homes in Detroit and they have not been found.

Senator HAWKINS. Thank you so much for relating this sad chain of events. We hope we have learned something from it and can get some expert advice on how to solve the problems and stop it from recurring in the future. We really appreciate your love and con-

cern and dedication to this problem that we face in the United States.

Now we turn to Mrs. Fran Sutcliffe, who is the Director of the St. Petersburg Nursing Home Hotline-Nursing Home Patrol. Is that what you call it?

Mrs. SUTCLIFFE. That is right.

Senator HAWKINS. Proceed, Fran.

STATEMENT OF FRAN SUTCLIFFE, DIRECTOR, NURSING HOME HOTLINE/PATROL, ST. PETERSBURG, FLA.

Mrs. SUTCLIFFE. Thank you, first, for inviting me today.

My name is Fran Sutcliffe and I am director of the Nursing Home Hotline, Nursing Home Patrol in Pinellas County. I am also a member of the State long-term care ombudsman committee and National Citizens Coalition for Nursing Home Reform.

The Nursing Home Hotline was started in 1974, because of the need in the community for a source of information and guidance in nursing home selection. The Nursing Home Patrol was started a year later when those who were calling on our hotline asked for more information regarding the laws, the rules, regulations and, finally, a general educational program.

The hotline is my home telephone number and I am available 24 hours a day. The patrol conducts six educational programs yearly. We are also a source of information for medicare and medicaid. There are no dues, fees, or assessments charged to our members or for our service. We ask only that people who call us for assistance also call us back at a later date to let us know which nursing home they entered and their evaluation of the care provided. We urge all to contact us without delay if a problem persists after consultation with the nursing home administrator.

The nursing home patrol is made up of all who call us for assistance. We find these are people who are interested in improving nursing home care because they are involved. They are families, friends, and volunteers. They are advocates for people in nursing homes who need a helping hand. If they notice a problem in a nursing home while they are visiting which they cannot correct, they call me and a solution is found.

I find with proper communication a great deal can be accomplished. Often we are contacted by nursing home employees, aides, nurses, and administrators. Aides call us when they are understaffed, overworked and, in their opinion, misused by management. Nurses call us to discuss a change in employers. Administrators call us when they feel we can assist in resolving a problem. Correcting problems is always a two-way street. I make it my business to listen to both sides. We place a special value on feedback calls. These are the people who usually see the problem firsthand. We believe most people complain as a last resort.

While they may not always be 100 percent accurate, there is usually some substance to their reports. Many are cases of negligence due to insufficient staff.

Regimentation is the key to control which leads to the denial of patients' rights. Some of the regulations which cause the greatest concern, in our judgment, are as follows:

The services of a consultant dietitian should be increased. Hundreds of patients in nursing homes will go to bed hungry tonight. Poor nutrition is a common problem.

Only last week a lady who had just returned home called me about the miserable food she had been served day after day in a nursing home. One Sunday evening she had been served two pieces of bony chicken fried to a hard knot. Another evening meal was grilled cheese sandwiches burnt black and hard. But she was lucky. She paid the aides to bring her a sandwich from McDonald's when they went out for their evening meal.

For the past 6 years the Florida long-term care ombudsman annual report has listed poor food as either the No. 1 or No. 2 complaint in the State.

Improper handling of medication in nursing homes is a common problem. I have been working with a daughter who had the experience of having her mother administered the wrong medication. Her mother was found in a semicomatose condition and rushed to a hospital. She survived only to be a complete invalid with brain damage, never to recognize her daughter again.

The third item of vital concern is infection control. To downgrade the importance of this vital function in a health care facility seems almost criminal. In a recent study done by the University of Utah, College of Medicine, about infection control and patients in a nursing home, the following facts were discovered:

Based on a 1-day survey in 7 nursing homes with a total population of 532 patients whose median age was 81, 97 infections were present in 86 patients, or 16 percent of the population. Thirty-two cases were of decubitus ulcers, commonly known as bedsores.

Other infections were urinary tract infections, upper and lower respiratory tract infactions, and diahrrhea.

The report further stated that educational efforts are important to prevent disease at extended care facilities. Simple techniques, such as handwashing after contact with each patient, must be taught. High staff turnover makes it imperative that in-service training in infection control is repeated often.

We urge you to help us retain the present regulations which we have worked toward in improving nursing home care in the past 10 years. We are still working to enforce and implement the present regulations, so let us not get involved in something different. We do need your help. We appreciate your interest in this, and we certainly thank you for your efforts which we feel resulted in the action that was taken over the weekend.

[The prepared statement of Mrs. Sutcliffe follows:]

TESTIMONY

FOR THE NURSING HOME HOTLINE-NURSING HOME PATROL, ST. PETERSBURG, FLORIDA

BEFORE THE U. S. SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

SUBCOMMITTEE ON INVESTIGATIONS AND GENERAL OVERSIGHT

MARCH 22, 1982

Madam Chairman and members of the Subcommittee:

Thank you for the invitation to testify before you today. 'My name is Fran Sutcliffe. I am director of the Nursing Home Hotline-Nursing Home Patrol of Pinellas County, Florida. I am also a member of the State Long Term Care Ombudsman Committee and the National Citizens' Coalition for Nursing Home Reform. The Nursing Home Hotline was started in 1974 because of the need in the community for a source of information and guidance in nursing home selection. The Nursing Home Patrol was started a year later when those who were calling on our Hot Line asked for more information regarding the laws, rules and regulations, and, finally, a general educational program. The Hotline is my home telephone and I am available on a twenty-four hour basis. The Patrol conducts six educational programs yearly. We are also a source of information for Medicare/Medicaid. There are no dues, fees or assessments charged to our members or for our service. We ask only that people who call us for assistance also call us back at a later date to let us know which nursing home they entered and their evaluation of the care provided. We urge all to contact us without delay if a problem persists after consultation with the nursing home administrator.

The Nursing Home Patrol is made up of all who call us for assistance. We find these are people who are interested in improving nursing home

care because they are involved. They are families, friends and volunteers. They are advocates for those people in nursing homes who need a helping hand. If they notice a problem in a nursing home while they are visiting, which they cannot correct, they call me and a solution is found. I find with proper communication a great deal can be accomplished.

Often we are contacted by nursing home employees, aides, nurses and administrators. Aides call us when they are understaffed, overworked and, in their opinion, misused by management. Nurses call us to discuss a change in employer, and administrators call us when they feel we can assist in resolving a problem. Correcting problems is always a two-way street and I make it my business to listen to both sides.

We place a special value on all feed-back calls. These are the people who usually see the problem first hand. We believe most people complain as a last resort. While they may not always be 100% accurate, there is usually some substance to their report. Many are cases of neglect due to insufficient staff. Regimentation is the key to control which leads to the denial of patients' rights.

Some of the proposed changes in regulations which cause the greatest concern are:

* The services of a consultant dietitian should be increased.

Hundreds of patients in nursing homes will go to bed hungry tonight. Poor nutrition is a common problem. Only last week a lady who had just returned home called me about the miserable food she had been served day after day in a nursing home. One Sunday evening she had been served two pieces of boney chicken fried to a hart knot. Another evening meal was grilled cheese sandwich burned black and hard. She was lucky--she paid the aides to bring her a sandwich from McDonald's when they went out for their evening meal.

For the past six years the Florida Ombudsman Annual Report has listed poor food as either #1 or #2 complaint in the State.

* Improper handling of medications is a common problem.

I have been working with a daughter who had the experience of having her mother administered the wrong drug. Her mother was found in a semi-comatose condition and rushed to a hospital. She survived only to be a complete invalid with brain damage--never to recognize her daughter again.

* The third item of vital concern is Infection Control. To downgrade the importance of this vital function in a health care facility seems almost criminal. In a recent study done by the University of Utah College of Medicine** about infection among patients in a nursing home the following facts were discovered:

Based on a one-day survey in seven nursing homes with a total population of 532 patients whose median age was 81,

97 infections were present in 86 patients, or 16% of the population;

32 cases of Decubitus ulcers, commonly known as bed sores;

Other infections were urinary tract infection, upper and lower respiratory tract infaction, and diarrhea.

The report further states that educational efforts are important to prevent disease in extended care facilities. Simple techniques such as handwashing after contact with each patient must be taught. High staff turnover makes it imperative that inservice training in infection control be repeated often.

We urge you to help us retain the present regulations which have helped toward improving nursing home care in the past ten years. We are still working to enforce and implement the present regulations. Please help us to protect those who cannot protect themselves. We need your support.

**Garibaldi RA, Brodine S, Matsumiya S: Infections among patients in nursing homes: Policies, prevalence, and problems. N Engl J Med 305:731-735, 1981. From University of Utah College of Medicine, Salt Lake City

Infections in Nursing Homes

Garibaldi et al conducted 1-day surveys in seven nursing homes in Salt Lake City to determine the prevalence of infections and factors that might place patients at risk. The total population of these seven nursing homes was 532 patients, whose median age was 81 years. The most common diagnoses were organic brain syndrome and organic heart disease. Incontinence was common: 260 patients were incontinent of urine or required catheters, and 199 were incontinent of feces.

On the day of the survey, 97 infections were present in 86 patients in the seven nursing homes, or 16% of the total population. The most common infections were decubitus ulcers (32 cases), conjunctivitis (18), symptomatic urinary tract infection (14), lower respiratory tract infection (11), upper respiratory tract infection (8), and diarrhea (7). Skin infections were significantly more common in nonambulatory, fecally incontinent, diabetic patients than among other groups. Lower respiratory tract infections were more common in patients who received sedatives or tranquilizers. Six of eight patients with upper respiratory tract infections were residents of one nursing home, and five of seven patients with diarrhea lived in another home. Clusters of lower respiratory tract infections and conjunctivitis occurred in several institutions.

Among 53 urine specimens from patients with indwelling catheters, 45 cases of asymptomatic bacteriuria were found. About two thirds of these specimens were colonized with bacteria resistant to commonly prescribed antibiotics. In all seven nursing homes, catheterized patients were allowed to share rooms.

Although all homes had infection control programs, none had regular training on infection control techniques. Garibaldi et al maintain that educational efforts are important to prevent spread of disease in extended care facilities. Even simple techniques, such as handwashing after contact with each patient, must be taught. The need for education is especially great because of the high staff turnover—almost 100% for aides and about 30% for nurses in all homes during the 3 months before the surveys. The authors also recommend that ill employees be restricted from direct patient contact—a potential problem because employees of six of these nursing homes were not paid for the first 3 days of sick leave, a practice that is not atypical among nursing homes.

Garibaldi RA, Brodine S, Matsumiya S. Infections among patients in nursing homes. Policies, prevalence, and problems. *N Engl J Med* 305:731-735, 1981. From University of Utah College of Medicine, Salt Lake City.

In an editorial accompanying this article, Avorn reflects on causes for the burgeoning nursing home population, which places increasing numbers of elderly people at risk for nosocomial infections. Revolutions in medical knowledge and technology have kept more people alive longer. Policy decisions of the 1960s, Avorn maintains, have placed many elderly people in nursing homes because costs of institutional care are reimbursed under Medicaid but community-based services are not. As a result, care of the elderly is viewed in a medical context, without regard for the social, financial, and other concerns of the aged. States Avorn, "We have developed an enormous medically oriented industry of geriatric care that is understandably ineffective in addressing the critical nonmedical problems of the elderly."

The high prevalence of infections acquired in the nursing home suggests that even the medical needs of the residents may not be addressed adequately. The study by Garibaldi et al, Avorn believes, confirms "that preventable infectious disease is common, and that the level of hygiene at the bedside is often primitive." Again, fault could be placed on policy decisions to operate nursing homes as efficiently, ie, as inexpensively, as possible. High patient-staff ratios mean that a nurse or aide may not be able to respond rapidly to a patient's request for a bedpan, leading to at least isolated episodes of incontinence and its potential ill effects. Staffing patterns and tranquilizer use may be as much responsible for incontinence, the editorial states, as bladder tone and urinary flora.

Although Avorn fears that correction of the fundamental misorientation in caring for the needs of the elderly will be slow, he finds hope in the teaching nursing home concept. He feels that teaching nursing homes may raise the standard of care and staff training in extended care facilities.

Avorn J. Nursing-home infections. The context. *N Engl J Med* 305:759-760, 1981. From Harvard Medical School, Boston.

Ross Laboratories is privileged to be associated with the production and provision of this information to members of the health care professions. Compilation and publication of this information constitute neither approval nor endorsement by Ross Laboratories or Abbott Laboratories of the opinions, inferences, findings, or conclusions stated or implied by the authors in the presentation.

Senator HAWKINS. Thank you, Fran. I think your reputation as a champion of nursing home patients in Florida has spread far and wide. Probably your ire better upset the Secretary than my ire, but together I know we got his attention.

I read recently that you will present yourself at the front door of a nursing home and expect the administrator to grant you an on-the-spot inspection. I thought it was so refreshing that you even received a public service award from the State's nursing home association for your efforts. I think that should be a great example to Floridians and citizens everywhere who are saying, "What can I do", or "I have nothing to do". You would be surprised at the amount of mail we receive from people asking for recommendations. They ask, "What can I do? I am 65 years of age and suddenly I have nothing to do." You set a great example of showing how you can put your life to a valuable benefit to others. I am staggered by the projections of our elderly population as medicine improves, and we are all going to grow older and older and live longer and longer. It is going to be an ongoing problem.

How did you first become involved in this? Could you tell those who are interested?

Mrs. SUTCLIFFE. Because I felt the responsibility for two elderly friends, two sisters, who lived together. The younger of the two died, leaving the older sister who was near 90, at the time. I continued to be concerned about her and went to her home daily. She finally fell and broke her hip and ended up in a nursing home. I was responsible for her. I had no information about nursing homes, just like the people who call me today that have to go to a nursing home. I was in that position.

So, after visiting her daily, I realized that I needed to know what the laws were and if they were providing the proper care and if they should be doing more than they were doing. Also, I found many other visitors there who knew as little about it as I knew. So, that was the beginning of it.

I started to find out what it was all about and do something about it.

Senator HAWKINS. Liane mentioned, and I am sure that you also subscribe to the importance of community involvement for long-term care facilities so that we can achieve the quality that we need.

Mrs. SUTCLIFFE. Well, I think it is absolutely vital that people, particularly those who have family and friends in nursing homes, who visit there, they are the ones to involve first. For those people to visit daily and see many problems that should be corrected, and abuse and negligence that should not exist and they do nothing about it, I think is next to criminal. I think they have to be aware of the fact they can do something about it, and they must have the courage to speak up and do it. There are far too many people who see something wrong and are afraid to say anything. As I say in my statement, the complaint is a last resort.

Senator HAWKINS. Who should they call?

Mrs. SUTCLIFFE. They should be in touch with the Director of the nursing of the facility or the administrator. Under Florida law, the administrator is the responsible party.

Senator HAWKINS. If they get no response from them?

Mrs. SUTCLIFFE. They can call the ombudsman committee. There is a district ombudsman committee——

Senator HAWKINS. How would they find that? Is it listed in the telephone directory?

Mrs. SUTCLIFFE. The law requires the administrator to provide this information to all who are admitted to a Florida nursing home. There is a folder about the ombudsman committee which tells what they will do, and their telephone number. This is true throughout Florida. Every nursing home in Florida should be distributing this information to people who come in.

Senator HAWKINS. You told us about the hotline that you run out of your home. I understand you do that with just volunteers and that you have not asked for a Federal grant to run this vital service. How do you do it?

Mrs. SUTCLIFFE. Well, do you want to know how it is paid for?

Senator HAWKINS. Yes; how do you get the money for it?

Mrs. SUTCLIFFE. Well, it comes about because I have a very kind and understanding and generous husband. You know, I decided quite awhile back that to be completely independent, to really tell the administrators what I thought, to tell people who call me what I think about nursing homes, I could not be accepting grants or salary or anything like that. The way to be independent is to pay your own bills.

I am fortunate that occasionally there is an organization that will come along and say, "Fran, we like what you are doing. Let us pay for the next folder that you send out."

I do send out a nursing home information folder. Sometimes people pay for a printing and that is great. I appreciate it. I say:

> Thank you very much, but don't expect a report from me. I don't make reports and I don't keep records. So, if you are expecting some great report to come from me to your organization because you made a contribution of $100, do not give it to me, because I do not want it. I accept absolutely nothing that has any strings attached to it.

Senator HAWKINS. I think you really demonstrate the worth of an individual and how important one can become. I was interested in your remark that regimentation is the key to control which leads to the denial of patients' rights.

Mrs. SUTCLIFFE. I think that is true in nursing homes. You know, everybody has to get up at the same time. The girls have to put everybody to bed at the same time. You have to eat your breakfast at the same hour. People should not lose their rights when they go into a nursing home. If they want to eat breakfast at 8 o'clock, or if they do not want to get up until 8 o'clock, that is the way it should be. They should not have to get up at 6 o'clock. That is one of the problems in nursing home care. Some individual things, some self-determination so their life is worthwhile is lost. I just think it is terrible for them to be so regimented. This is a matter of public input. I mean, the visitors can make that difference. We must encourage these people. They need encouragement.

Senator HAWKINS. They need visitors. I have been to some of these homes——

Mrs. SUTCLIFFE. They need visitors and encouragement to do their own thing.

Senator HAWKINS. And, as you say, if the visitors then would say——

Mrs. SUTCLIFFE. The visitor must be interested enough to speak up on behalf of these people.

Senator HAWKINS. That is important. We have so many organizations in the State who are looking for projects, looking for some worthwhile projects. I can think of nothing more worthwhile——

Mrs. SUTCLIFFE. It would be great if we could get them more involved. I think the church people are taking a great deal more interest than they did, at least in this area.

Senator HAWKINS. I know there is much competition in hospital care, for instance. That also comes under my committee. I have been reading the advertisements that hospitals are now extending, trying to compete for patients. They are saying,

> We don't wake you up at 7 o'clock with a cold thermometer. We wake you up at 9:15 with the morning paper and a cup of coffee. So, if you have to go to a hospital, come to our hospital.

It seems to me that they have low occupancy in the beds because we have so many hospitals in the State of Florida. Nursing homes could take a page out of that book——

Mrs. SUTCLIFFE. Indeed, you are right. Absolutely.

Senator HAWKINS [continuing]. By saying that the nursing home resident is the one that can call the shots. Some of us like to get up very, very early and go to bed early. Others like to sleep late in the morning and do things that are not, as you say, so regimented. I think that would extend their lives a great deal, and the quality of their life each day would be so much more worthwhile.

You made a request that the present regulations be retained. We have the statement from Secretary Schweiker that they will be, but also I have learned, sitting on my side of the aisle, that we should not let down our vigilance whatsoever. It does not mean that they cannot be changed next week. Therefore, we should constantly monitor and report. We really appreciate your information and your advice and the great example that you set.

How many nursing homes do you feel meet the current regulations?

Mrs. SUTCLIFFE. In Florida?

Senator HAWKINS. Yes.

Mrs. SUTCLIFFE. We have about 360 nursing homes in Florida now, maybe 25 percent.

Senator HAWKINS. So, even they need some help in meeting the present regulations?

Mrs. SUTCLIFFE. Well, as far as the medicare and medicaid homes are concerned, we have a very definite problem in our office of licensure and certification due to the cutback in medicare funding last year. We are at this time 44 people short in our office of licensure and certification. These are the people who make inspections in nursing homes in Florida.

Senator HAWKINS. We will make note of that.

Mrs. SUTCLIFFE. So, cutting medicare programs on that level has really hurt the elderly. I do not know what they are going to do in the future. Of course, HHS is talking about going to the joint commission [JCAH] for inspection. If they do that on the medicare

level, it will further cut funds for inspections we now have on an annual basis. This move would also eliminate followup calls which check corrections. It is true throughout the United States, not only here.

Senator HAWKINS. We will stay in touch with you. I know that you will keep us informed, especially my subcommittee. We, in turn, can feed that back to the administration. I know we have to do better with less because of the current economic conditions and I think it is suitable if we all work together and find out from people like you who are involved on a day-to-day basis. I certainly want to commend you again for your contribution to community service.

Mrs. SUTCLIFFE. Thank you.

Senator HAWKINS. We now welcome Mrs. Ethel Glass, who is a member of the Gray Panthers. We would like to hear your statement.

STATEMENT OF ETHEL GLASS, TASK FORCE CHAIRPERSON, GRAY PANTHERS, SUNRISE, FLA.

Mrs. GLASS. Senator Hawkins, I am indeed Ethel Glass, chairperson of the Health Task Force of the Gray Panthers of Broward County. I do appreciate the opportunity to testify before you today regarding the views of the Gray Panthers relative to the quality of care of the elderly residents of long-term care facilities in Florida and to offer our comments on the proposed revision of Federal regulations governing nursing homes. I speak from several positions. As a senior citizen who may at sometime be requiring the services of a long-term care facility, but who among us is not aging?

As a consumer member of the Health Planning Development Council of Broward, who was actively involved in developing goals and standards for inpatient long-term care services for Broward County, a copy of which I forwarded earlier to the committee.

Also as a visitor and observer of the many long-term nursing facilities in our area.

First let me firmly state that we, the Gray Panthers, are unalterably opposed to further deregulation of the nursing home industry since the results can only be further dissolution of professional staffs maintained in the medical and nursing areas as well as all other areas of service to the vulnerable clients of some of these facilities.

A primary fallacy of the present proposal is that it addresses itself exclusively to medicare and medicaid servicing facilities, leaving totally unregulated those nursing facilities that cater totally to the private sector. Not only might the latter group become totally impoverished economically, but the conditions under which patients exist could become intolerable. By not including the private sector, you are establishing a dichotomy of standards of patient care and a definite lack of standards for private patients.

Moreover, it would discourage even further, if that is possible, the participation of nursing homes in the long-term care of medicare and medicaid patients since if they were not participants they would not be regulated. We cannot stress strongly enough—and I underlined this in my notes—all skilled nursing facilities should

have definite standards and procedures to which they must adhere. We need improved legislation to regulate nursing home practices with such clout that meaningful penalties for violations are assured. Those who do not comply with established standards of care should be forced out of business.

Another deficit is the need for greater improvement of consumers in the inspection and evaluation process with access to the facilities without prior notification. Each facility should be evaluated at least once a year with more inspections where many infractions are uncovered, the ombudsman program should be strengthened in quantity and quality with the ability not only to suggest, but to implement changes where necessary. With the proper standards established, the consumer members of the inspection team could assume this responsibility incurring no additional expense. They should have periodic consultation with representatives of the Patients' Rights Committee, which should be a definite part of the program of each nursing facility. The Ombudsman Committee should be strengthened in quantity and quality with the ability not only to suggest, but to have access to the body that would enforce change if necessary.

We ask you to remember that nursing facilities are a business for profit, and that they have become a most profitable industry, indeed. There is nothing wrong with making a profit, but must it be exhorbitant? Must it be made at such tremendous costs in human suffering and misery?

Medicaid and medicare are supposed to provide health care to the poor, the elderly, and the disabled. Instead, these programs have made the providers, the doctors, the nursing home, the drug and equipment manufacturers richer while failing to provide desperately needed care. May we ask that you consider the client of a nursing home, the ill patient, not as a disease but as a physical being, a mental and emotional being, a social being, and in total as a human being.

In that context, I refer you just to a few items in your own draft of proposed deregulation. I will only take a few so as not to waste your time. On page 21, if you care to refer to it, paragraph 1, line 5, it says,

> Each patient's discharge plan must include pertinent information to indicate the patient's readiness for discharge and must specify the health, social and welfare community-based services needed after discharge.

We say it should specify contractual agreements indicating who is responsible, where is service to be rendered, when, how and how often is it to be rendered.

One of the other items was under your medicare and medicaid programs. It was under utilization review, page 18. In this rule, and I quote from your proposed deregulation, "We are proposing deletion of the standards on medical care evaluation studies."

We say to you in that case how would appropriateness be evaluated and what standards would be used?

On page 21—I am reading from your notes——

Senator HAWKINS. I would like the record to reflect those are the Health Care Finance Administration's notes and not mine.

Mrs. GLASS. I beg your pardon. I took them from the committee. I am sorry. I assumed they came to me through the committee.

Senator HAWKINS. That is all right.

Mrs. GLASS. For example, that a patient be specifically identified before administration of a drug and that drugs and biologicals be administered as soon as possible after doses are prepared. These procedures are intended to assure that drug administration errors are avoided; however, a Health Care Financing Administration, HDFA study has shown that the drug administration error rate is not necessarily influenced by compliance or noncompliance with these and other process standards.

As a result of further consideration of the issue, the Department has decided to exercise an outcome standard in lieu of the process standards it currently relies upon. The outcome standards proposed in these regulations would require that the facility's drug administration error rate not exceed 2 percent. By deleting the process standards, these regulations would also free a facility to modify and manage its procedures for drug administration in any way it sees fit so long as compliance with the error rate is achieved.

We say who would be responsible for enforcing a change in procedures if and when it became necessary? When and how often would this be evaluated? How many would have to die unnecessarily and how would we like to be part of the acceptable and allowable 2 percent?

On page 24, line 3, from the notes, requirements for weekly time schedules showing the number and times of nursing personnel on each tour of duty would be deleted since such specificity is not necessary for Federal regulations. We say these records should be required under Federal regulations. Would these not be necessary to insure that there is adherence to the prescribed standards and would it not be necessary for evaluation of personnel and to fix responsibility for actions taken and for errors made?

Under "Patient activities," page 26 of the notes, "This proposal would continue to maintain this item as an independent condition." I ask what does that mean? "However, we would delete the provisions regarding the qualification of the person responsible for patient activities and the need for a consultant under certain circumstances. This is an administrative item that is left to the facility."

We think not. The individual should be qualified to perform these duties and should be working together with the Patients' Rights Committee. Surely they have a right to indicate those activities that have greater appeal and, therefore, greater utilization.

On page 33, paragraph 2 in the notes.

Regulatory flexibility analysis, as explained above, the intent of this rule is primarily deregulation thereby giving skilled nursing facilities and their administrators maximum flexibility in the setting of priorities and the use of resources. This would be achieved by deleting from Federal regulations certain staffing requirements, such as the Patient Activities Director and various management concerns best left to the discretion of the facility such as how often patient care policies should be reviewed.

We say since the skilled nursing facilities deal with a clientele which is totally vulnerable, the skilled nursing facilities and their administrators having "maximum flexibility" in setting priorities

and in use of resources is tantamount to giving them license to do just as they like, for as long as they like bearing in mind that this is, indeed, a business for profit.

The former represents only a few of the many items which must be considered. We cannot believe that you could honestly tell your constituents that you have their well-being in mind when voting for the proposed rules and after a page-by-page and line-by-line evaluation of the proposals, we must reiterate our position that these regulations are regressive and negate completely the hard won reforms of many, many years.

We ask that you hold this thought in considering our additions and deletions.

Thank you for listening.

Senator HAWKINS. Thank you so much. As you know, I have been opposed to most of the proposed changes. I do not know if you were aware of that or not. That is why we had this hearing today because the Department is proceeding merrily along with the revisions without having had a hearing. We felt a hearing was most important to get facts upon which to make the judgment. Obviously, they made a hurried judgment over the weekend. As you have heard, Secretary Schweiker has announced that there will be no changes in Federal regulations, at the moment. His statement was couched in terms referring to regulations "which directly affect patient safety and health", which to me would mean all things.

I know you were very active in the planning for long-term care facilities in Broward County, which is Fort Lauderdale, a very fast growing area. I was there last week.

What do you see as the goal of long-term care institutions?

Mrs. GLASS. In the first place, to make them less like institutions. One of the things I pointed out here, and I have personally visited several of these long-term care facilities as an interested individual concerned with the patient, et cetera, and all too often I have found that in no way are these individuals involved in any of the decisions that are made regarding their lives within the facility. I am not discussing, of course, medical decisions or anything of that kind, but surely there should be a Patients Rights Committee in every facility so the patient can have somewhere to go if it is only to feel that there is someone to listen to them. They cannot speak to the nurse. They cannot speak to the Director. I myself would be loathe if I was under the care of an individual to go to that individual and complain about someone with whom they are having direct contact. It is not feasible. I think that this is one of the things that is totally, totally—I could not agree more with Fran Sutcliffe, that it is so important to a degree to be able to maintain almost their individuality so they can even voice an opinion. Even if it is something you cannot adopt in toto, possibly you can thank them for having made this suggestion and maybe implement a little part of it to make them feel they are indeed still functioning and they still have a place, you see. That together with greater concern for—one of the items I picked up that really caused me to have even more grey hairs than I have, is that the drug administration—I absolutely blanched when I read it. I think that that is something I would ask you to pay very careful attention to.

Senator HAWKINS. I am vigilant on that.

We thank you so much. You and your organization are to be commended for your grassroots efforts. We are going to be calling on you again, I am sure, before this battle is over.

Our last witness on this panel is Mr. James Humbles, a member of the Statewide Long-Term Care Ombudsman Committee, which investigates nursing home complaints.

Mr. Humbles, you have a hard act to follow.

STATEMENT OF JAMES L. HUMBLES, MEMBER, STATEWIDE LONG-TERM CARE OMBUDSMAN COMMITTEE, DOWLING PARK, FLA.

Mr. HUMBLES. Do I not know it. I was going to be optimistic in my report, Senator Hawkins.

I think I should identify that I am a nursing home administrator. I am an ACLF administrator. I am on the ombudsman committee and I am on the board of directors of the Florida Association of Homes for the Aging, which represents only nonprofit organizations.

In some ways I really do not know what to say after hearing all of these things, but I will assure you that as I speak specifically for the ombudsman committee, I have no conflict with what I am saying as an administrator of facilities. We are hearing an awful lot of negative things about them. I heard good news this morning as I came in about the decision Secretary Schweiker had made. That was very good news.

We do still have some concerns, of course, not so much now in the rules and regulations, but in the enforcement of these rules and regulations. I am sure that there will be persons on the panel who will speak on those issues.

Let me begin by talking about our advocacy system here in Florida. We think that we have a very good one, a very strong one for its residents of long-term care facilities, known as the ombudsman committee.

There are 11 district committees and 1 statewide committee. These committees were established in 1975 by the legislature. They have been established to receive, to investigate, and resolve complaints on behalf of nursing home residents. The committee members are appointed by the Governor and serve without pay for their time and services. The legislative intent in establishing these committees is to assure that residents living in nursing home facilities are afforded the independence and dignity as they live their later lives. That is what we are hearing so much about this morning.

The first priority of the district ombudsman committee is to receive and investigate complaints from individuals living in nursing homes or from family members or other interested persons.

In 1981, our district committees received a total of 713 complaints. My guess is that this is just the tip of the iceberg in terms of really the number of complaints that are filed in the State. For example, Fran and her hotline certainly don't report or keep up with those. So, these are the ones that have come directly through the ombudsman system. This number of complaints represents only a portion. In many cases the complaints which reach the ombudsman committee can be resolved in a cooperative spirit by a commit-

tee member, by the person issuing the complaint and the facility administrator or staff.

I think what needs to be underlined is that an awful lot of these complaints are resolved in a cooperative spirit among the people involved. However, when complaints cannot be resolved at that level, the committee has several options in seeking a resolution. Oftentimes we turn to another State agency in assisting us in verifying and resolving complaints. Other times we find it necessary to go public and use the press with the complaint. In this process and in all of our processes of being advocates for residents, the individuals are not identified. Our effort is to protect the interest and the identity of the one who filed the complaint and serve as his advocate in seeking a resolution.

Now, the committees, obviously, do a lot more than simply receive complaints and investigate them. The committees are involved in programs of interest with the districts. They certainly make their voices known and heard by their local legislators and by the department of health and rehabilitative personnel. We are seeing some things taking place in the State legislation just this year because of the role the ombudsman committee is playing. Of course, annually we prepare a detailed report that goes to the Governor, to the State senate and house, and to the department of health and rehabilitative services. The regulations are carefully considered and are in many cases, implemented by law or rules to assure that the well being of a most precious resource, our nursing home residents, is protected and encouraged.

Now, I would like to be optimistic because I think there are a lot of good things that have taken place in Florida. On April 1 of this year, new rules and regulations will be implemented here in the State, and we think they are a good set of rules and regulations that will have an effect on the care given to residents in our nursing facilities here in the State of Florida.

We have a new reimbursement system, hopefully. You will be hearing more about that from Mr. Palevsky, I am sure. It is long overdue and, whether we like it or not, money and patient care do have a relationship. We are going to have a reimbursement plan here in Florida that is going to assure that more of the available dollars go for direct patient care. We ought to be proud of that, and we are.

Those of us who have been involved in it or who have worked on it are really excited about the prospects. If you have pull here in Florida, you could let the Legislature at the State level know that we need this 1 cent sales tax increase right away.

Even though the good news was reported this morning that the rules and regulations are going to stay intact, we do have some concerns about what this is going to mean in long-term availability of funds for inspection and for licensing here in the State. We do have some concerns about whether or not the Joint Commission on Accreditation of Hospitals is going to take over this process for the Federal Government. We have some concerns as to whether or not those inspections are going to be the kind of inspections that we in Florida are going to be satisfied with and are going to want to live with.

We have some real concerns about the enforcement process and who is going to do the enforcing. It is my understanding that the joint commission probably would not do that.

I would, as an administrator of a nursing home, very much like to be like Fran. I would like to be independent and operate my facility exactly the way I want to. I think I could and would operate a good facility, but all of us who do operate good facilities in the State are bright enough to realize that we have to be accountable. That we simply cannot be permitted to have free rein over the kind of care that we are going to give our elderly here in the State and I think nationally.

What I hear administrators complain about is not so much the rules and regulations, but paperwork. I think there is always a way and there should always be a system of reviewing and revising so that there can be less of that kind of thing, but, at the same time, discovering methods or procedures of assuring that residents are getting the care they need. There just has to be some kind of creative way available to us as administrators, and other staff in nursing homes, to give care without spending the enormous amount of time that we do. Especially those of us who are involved in medicare and medicaid and whatever else we can get our hands on to run our programs. So, that is what I hear very often from administrators. They say, "Find us a way to live within the rules and regulations, but to be able to do it with a lot less paperwork."

I thank you for this opportunity of speaking to you and any way the ombudsman committee and others here in the State can be helpful, we want to be a part.

[The prepared statement of Mr. Humbles follows:]

REPORT TO THE SUBCOMMITTEE ON INVESTIGATIONS

AND GENERAL OVERSIGHT

March 12, 1982

I believe that Florida is on the threshold of change in caring for those elderly citizens who live in long-term care facilities and nursing homes. Dramatic change is long over-due. Many have come to realize that the "band-aid" approach will no longer work. There are going to be several stumbling blocks to this change, but I am extremely encouraged by what is happening. Florida needs to be the national leader and example in giving quality care to our aged. This has not always been the case; it is not the case now. But, Senator Hawkins, I am convinced that one day you will be able to say with a great deal of pride to your peers in the U. S. Senate, to your acquaintances in the Washington scene, and to interested citizens throughout the country, "Come on down to Florida and let us show you how we serve our elderly who live in our nursing homes." Change is occurring and will be occurring at a rapid pace over the next couple of years.

Why am I so optimistic? Is this an unrealistic dream that is going to turn into a frightening nightmare? I don't think so. Here's why.

1. First of all, it has been recognized by the Florida Legislature, the Department of Health and Rehabilitative Services, the Florida Health Care Association, the Florida Association of Homes for the Aged, the Ombudsman Committees, and those who live in our nursing homes that a new plan of financial reimbursement is needed to assure that adequate resources are available to our nursing homes who serve the medicaid recipient. The present plan is one of the stumbling blocks in Florida in assuring that less than quality care be given to our citizens. Actually, the present plan has

> (probably unintentionally) built into it incentives to spend as few dollars as possible on direct patient care. However, even if a nursing home avoids the temptation to give less than decent care to its residents, the reimbursement ceilings are inadequate to assure proper reimbursement. But, a new day is dawning. In the words of Dr. Irving Vinger, chairperson of the Long-Term Care Ombudsman Committee in the Miami area, "The 'Gainesville Plan', if adopted now, would revolutionize nursing home care in the State of Florida." This Gainesville Plan, the proposed new Medicaid reimbursement system will indeed create dramatic change in the State of Florida. If adequate resources are provided for this plan to assure that an appropriate amount of dollars go to direct patient care, then we can begin to have confidence that good and decent care will be given to our nursing home residents who must depend on the Medicaid dollar for their livelihood.

What are some of the major characteristics of this new plan that can assure that available dollars are more effectively used in caring for our elderly? First of all, three separate cost centers will be established. These centers include property costs, direct care costs, and administrative costs. The direct care and administrative cost centers will have separate ceilings. The plan will permit and encourage nursing homes to spend more of their medicaid dollars on direct resident care. Presently, our reimbursement plan actually encourages less spending in direct resident care. Secondly, there will be financial incentives to encourage nursing home administrators to give adequate care to residents. Thirdly, nursing homes will be classified according to their size and geographical location.

They will be reimbursed according to established ceilings within their class size and location. Fourthly, the new plan will establish a single level of care payment. This means that nursing homes will be reimbursed at the same level for Skilled, Intermediate Level I, and Intermediate Level II. This will discourage attempts at manipulation of the system which presently encourages nursing homes to serve only those where the highest reimbursement can be assured.

Many of us in Florida are excited about the changes that will occur because of this new reimbursement plan. Our Medicaid nursing home recipients deserve good, quality care. Before long, in Florida, there will be no reason why they should not receive this care.

2. On April 1st of this year, new state rules for nursing homes will go into effect. These rules may perhaps be the most progressive of all rules of the states. Rules that will assure, along with the reimbursement system, that our residents in nursing homes can be well cared for in surroundings that are appropriate in character and in safety. The Department of Health and Rehabilitative Services, with the support of the legislature, the Long-Term Ombudsman Committees, and the nursing home industry has worked diligently to establish rules and regulations that will help assure that our residents will receive appropriate care. The implementation of a rating system along with the rules will give potential residents and their families, as well as the general public itself, the opportunity to know whether or not a nursing home is classified as "Superior," "Un-rated," (meeting standards) or "Conditional." This information could be invaluable as families

"shop" for nursing facilities for their loved ones.

3. Many in the State of Florida have been discouraged over the years by the lack of education and training required for nursing assistants who give the most direct care to residents in nursing homes. I am pleased to say to you that change is on the way. First of all, the new state rules themselves require that every facility have a well-developed staff educational plan that assures adequate pre-service and in-service training be given to every nursing home employee. This is especially critical with nursing assistants who in many cases have received no formal training in the area of health care. Secondly if certain specific legislation is passed during this session, we can be assured within the next couple of years that there will be a state-wide program of certification for nursing assistants. This is great. This is needed. The state and district Long Term Care Ombudsman Committees have been stressing this need for several years. The persistence of these committees and other advocates of good quality care for nursing home residents is paying off.

4. The State of Florida has a strong advocacy system for its residents who live in long term care facilities. These committees - one state ombudsman committee and eleven district ombudsman committees - have been established to receive, investigate, and resolve complaints on behalf of nursing home residents. Committee members are appointed by the Governor and serve without pay for their time or services. The legislative intent in establishing these

committees is to assure that residents living in nursing home facilities are afforded independence and dignity as they live their later years. The first priority of the district Ombudsman committees is to receive and investigate complaints from individuals living in nursing homes or from family members or other interested persons. In 1981, our district committees received a total of 713 complaints. This number of complaints represents only a portion of the complaints for many others are referred directly to other departments and agencies in the state. In many cases the complaints which reach the Ombudsman committees can be resolved in a cooperative spirit by the committee member, the person issuing the complaint, and the facility administrator. However, when complaints cannot be resolved at that level, the committee has several options before them in seeking a resolution. Often times we turn to other state agencies in assistance in verifying and resolving complaints. At other times, we find that it is necessary to "go public" with the complaint. In this process and in all our processes of being advocates for residents, the individuals involved are not identified. Our effort is to protect the interest and identity of the one who files a complaint and serve as his advocate in seeking a resolution.

Of course, the committees do much more that receive complaints and investigate them. The committees are involved in programs of interest within the districts; they make their voices heard by their local legislators and Department of Health and Rehabilatative personnel; and

annually the state and district committees present a detailed report to the Governor and legislature regarding activities of the past year along with recommendations for future consideration. The recommendations are carefully considered and are in many cases implemented by law or rules to assure that the well-being of a most precious resource - our nursing home residents - is protected and encouraged.

Throughout this report to you, I have attempted to stress strongly the fact that we have much to be encouraged about regarding the state of nursing homes in Florida. A proposed new reimbursement system, new rules and regulations, a sensitive public and legislators, quality training programs, and a strong advocacy system. I have also along the way identified some stumbling blocks. However, I would like to suggest that a major stumbling block is the possible dismantling of nursing home rules and regulations at the Federal level. Nursing home care is not a problem limited to the State of Florida. It is a national problem, and therefore should receive national priority and interest. We are a mobile population which regularly and often moves from state to state. Older citizens in their retirement years move to states of warm climate -- away from their established friends and families. Adult children living in distant states who are concerned about their aging parents often move them to nursing homes close to where they work and live so that they can give the family attention that is so important. Is there any justification in assuring that good care be given in one state while indecency be permitted in another state? Do we not have an obligation to assure to the best of our ability that all of our nursing home residents throughout our great country be given the opportunity to reside in a "community" that is guided by high standards?

As an administrator of a nursing home, I would like very much to be able to operate our facility without any rules or regulations from either the state or federal government. My staff and I become weary of unnecessary and expensive paper work. I weary of having to implement rules and regulations that have little meaning in terms of quality care and the protection of our senior citizens. However, hopefully, I am bright enough to realize and to accept that laws and rules and regulations must be required of me to assure that I am doing what is necessary to give meaning to the lives of those who live in our nursing homes. Rules and regulations should not be destroyed; instead, they should be regularly reviewed and revised. Times and attitudes change; therefore, laws and rules must also change. There must be flexibility to allow for innovation, creativity, and even something better than what rules and regulations themselves require. But the answer is certainly not to let us go our "merry way" without accountability. Universal guidelines to assure consistency of our obligations is a must. I urge you, Senator Hawkins, not only to be proud of what is happening in Florida, but also to be proud of what's happening to our nursing home residents throughout all of our states. Many of us in this state support the wish for less paper work, but we never support that wish or dream at the expense of necessary legislation or rules and regulations that could possibly assure the well-being of our residents in our nursing homes.

It has been a real pleasure to have this opportunity to speak to you today. Thank you for your concern, interest, and sensitivity to the needs of our older citizens.

Respectfully.

James L. Humbles
Vice-President, Advent Christian Village

Senator HAWKINS. We look forward to working with you, Mr. Humbles.

You mentioned that you had 713 complaints referred to your committee during the last year. What were the most frequent? Do you have any categorization of those complaints?

Mr. HUMBLES. Yes. Of those, over 700 complaints, approximately 39 percent of them, had to do with direct patient care problems. This had to do with the attention to their patients' needs, professional nursing care, abuse, negligence, patient hygiene, and again the quality of food service is always up near the top in terms of complaints. Most of the complaints that the committee receives have to do with those things that directly affect the patients and residents in a nursing facility. Other complaints are certainly received—there are many administrative complaints. That is probably the secondmost. This comes about through billing problems. There may be some questions about billing procedures or amounts charged, staffing patterns, policies within the nursing home, contracts and so forth, but most of the complaints definitely have to do with problems that are directly related to patient care.

Senator HAWKINS. And were you able to do something about that? I mean, if 39 percent of the 713 complaints have to do with patient care, I would translate that to mean that probably all nursing homes across the board have this same problem; therefore, as an ombudsman you could send a bulletin or whatever is necessary to say that this particular problem has come up again and again, and make them more aware of it.

Mr. HUMBLES. I do not know that we have done that directly to the nursing facilities. We certainly report this kind of information annually in our annual report.

Senator HAWKINS. I have seen the annual report. It just seems that rather than it becoming an annual statistic it could be corrected, as the ladies here have said they do on almost a daily basis. Perhaps you cannot, because of the amount of paperwork that it takes. I am very sympathetic with that problem. I think that with a lot of good thought and the machines that are available today that were not available just 4 or 5 years ago, you could cut way back on the paperwork and have quality care. I personally would rather have human beings dealing with human beings and let machines fill out papers. It seems like we are not using our resources in the right place.

I understand in 1980, the Florida Legislature expanded your functions to include advocacy on behalf of the ACLF's that Liane was speaking of, and of adult foster home residents.

What problems were peculiar to those types of facilities? Can you help us on that one?

Mr. HUMBLES. Because this is a relatively new part of our responsibility, we have not been getting the response from the ACLF residents and from their families, but I think we will get it in the future.

We received under 100 formal complaints last year, and again the complaints—we really do not have enough to determine whether or not there is a trend here, but again they are directly related to resident care in this case. So, in the nursing homes they are directly related to patient care and the ACLF's most complaints are

related to patient care. Again, anywhere from safety in ACLF's to abuse and neglect and hygiene to lack of attention to the needs that are being met. We are also getting complaints in the area of residents' rights from our——

Senator HAWKINS. Residents' rights?

Mr. HUMBLES. Right, residents' rights that have to do with privacy and freedom of communication. Very often in our ACLF's, depending on the type and style of ACLF's, there is just not the privacy that the resident needs.

I think some of our ACLF's are operated very much like our educational institutions were operated a few years ago. In education we just loved this philosophy of "in loco parentis." I think we see that in the ACLF's. You know, the administrator is the mom or the pop and, therefore, we will decide what is best. We will decide what to do and when you do it and so forth. We are going to have our hands full, I think, in changing and reeducating our administrators, especially those of our smaller ACLF's that may be caring for a small number and have not had any type of formal training.

Senator HAWKINS. I wanted to ask you about that. In 1981 the statewide ombudsman committee recommended applicants for a nursing home administrators' licenses complete a college level education program with a curriculum specifically designed for nursing home administrators. What does the ombudsman committee see as the importance of increased educational requirements for nursing home administrators? Do you think it also will flow down to the ACLF's?

Mr. HUMBLES. We certainly think there has to be an increase in the educational level of nursing home administrators. We think that has to be academic education. We think there certainly has to be some good in-service or practical experience. There has to be competence exams. We think improvement of our facilities starts at the top. We think if we don't deal with the improvement of administrators we cannot really expect improvement through the organization, through the facilities.

My concern in terms of the ACLF's is that we have just so many different types of ACLF's. I am not sure, for example, that someone with a baccalaureate degree in terms of making a living for himself is going to run an ACLF with four or five persons in it. So, I think there has to be different types of training for different types of ACLF's.

One of the major problems, I think, that we are faced with in this State in terms of ACLF's is there are just so many different types of facilities. Where the residents are really independent, they live in nice apartments and receive supportive services as they need them. Some may be in a setting where you have 200 or 300 residents living together. Then there are the smaller facilities where they are maybe caring for four or five people; and the needs are different than those living independently in the ACLF's.

So, I think there is going to have to be some consideration given to what kind of training can be effective for our ACLF operators and administrators. I am not too sure that the same type of training for one type is going to be appropriate for another type.

Senator HAWKINS. No, probably not. We need to individualize the facilities. I hate calling them institutions. We have all started call-

ing them institutions and they have turned into institutions, which is what we do not want. It seems to me the personal touch would come by limiting their size. The training probably should be the same. I am sure you are going to have less trouble if you start to educate now than if you wait 4 or 5 years when they are way beyond control.

It seems there is a spirit of cooperation here. We are dealing with solutions to difficult problems. We are dealing with more than one kind of care for our elderly. We have in Florida probably the broadest representation of all types of care. The ombudsman's responsibility should be at least to discuss these issues, as you have done. I have found there are very few problems that cannot be solved by communication. We certainly have a good network here in this State, and by working together we can solve these problems sooner than later.

One of the big items I think that should be on your agenda is how to cut the paperwork load. You cannot wait for something to come from the bureaucrats in Washington because they love paper. They deal in paper. They are covered up in paper. If you wait for new recommendations for less paper to come from them, sometimes the directions are so voluminous that you would rather live with the old ones. I find the best ideas come from people like you who are on the firing line, those that have to fill out the sheet of paper and who question whether we really need that questionnaire or that piece of paper. I think that now that we are in this reviewing stance concerning nursing home care and care for the elderly, it is a very good time for your organization to work with the other organizations and send in recommendations. You might have the solution right here at your fingertips. I personally think it is going to come from Florida where we have the largest number of active elderly.

I certainly thank you for your time and your ongoing concern and hope you will stay in touch with us. I am sure this is the first of many hearings we will have and we will share all of this information with the rest of the committee.

Panel No. 2 consists of Mr. Elliott Palevsky, Dr. Eric Pfeiffer, Ms. Pam Parker, and Mrs. Virginia Haggerty.

If you could summarize your statement, then we will go right to questions.

Mr. Palevsky has a plane to catch. We will start with Mr. Palevsky. If you could, summarize your statement for us, please.

STATEMENT OF ELLIOTT PALEVSKY, FLORIDA ASSOCIATION OF HOMES FOR THE AGING, EXECUTIVE DIRECTOR, RIVER GARDEN HEBREW HOME, JACKSONVILLE, FLA.

Mr. PALEVSKY. Thank you for the opportunity to address you. I really came out of concern for the deregulation process, which has just been at least held in abeyance. For the majority of recipients of long-term care the maximum that might be hoped for is the minimum required by applicable regulations. The attempt to lower minimum requirements is indicative of the misunderstanding of what the role of long-term care really is and what the problem with regulation really is.

Long-term care, as you pointed out, for 80 percent of those who come to live in a nursing home, is their community of permanent residency. Only 20 percent will return to the larger community because of a change in family ability to provide care or through good rehabilitation programs. The suggested removal of requirements for professional activity guidance and professional social services as well as informed medical direction indicated that long-term care was again being viewed as a warehousing process. When long-term care is effective, what you have established is a prosthetic community, where the total life process goes on. That community is enhanced by available services, but should not be defined by those services.

The enhanced service environment is what differentiates this long-term care community—nursing home—from the larger community to which it relates. Psycho-social, medical, nursing, mental health, and personal care services are the vital resources required by the long-term care resident. In part, these services and resources compensate for the great diversity of functional, medical, and emotional deficits which necessitate the long-term care placement. Services are applied also to minimize future risk to a highly at-risk population and to create an environment which would allow for optimal, physical, and psychosocial function.

Long-term care is chosen or "backed into" when the configuration of care and support needs of a person become too complex for appropriate response within the community at large.

The availability of enhanced resources is the first condition necessary for effective long-term care. Necessary does not mean sufficient. Resources and services must be aptly and discerningly applied by a professional interdisciplinary care team. Also, the long-term care resident and family must be able to adjust—with professional help if necessary—to new realities and avail themselves of new opportunities before continued meaningful living can take place. However, nothing is possible without the necessary resources in place.

The so called attempt at deregulation was an attack on these resources and did not address the major complaint of most long-term care administrators, i.e., overwhelmingly burdensome paperwork due to requirements that the total life process of a long-term care resident be documented according to an acute hospital care model.

Instead, the so called deregulation was aimed at removing minimum requirements for the vital resources necessary to the provision of long-term care, i.e., professional medical, social work, and activities direction. Also under consideration was the elimination of the requirement for a functioning interdisciplinary care team, which is the one specialized took most appropriate to the assessment, planning and delivery of long-term care as well as weakening the force of the requirements for the protection of resident and patient rights.

Many of us committed to quality long-term care have called for an increase in minimum service and resource requirements as well as for the funding to make this possible. At the same time, we plead for a decrease in those documentation requirements which serve no purpose in the long-term care process other than to replicate the inappropriate hospital charting model. Hospital charts

tend to be limited to a specific problem for a limited duration, while nursing home charts must reflect the total life process as it occurs within the long-term care facility.

We have also long requested that applicable code requirements not be interpreted and enforced in a manner which forces the care provider to organize the life of the resident into a collection of so many notes, charts, services, therapies, special diets, square feet, positive latching devices, astragals, et cetera, et cetera in order to achieve reasonable code compliance at an effective cost.

Alternate models of quality control are available which would induce providers to organizer services within the social-medical model more appropriate to the purposes of long-term care.

Let me ask you, have you ever been in a hospital?

Senator HAWKINS. To tell you the truth, I just took my collar off for this hearing. I just got out of the hospital.

Mr. PALEVSKY. I have been in hospitals and I can imagine having to be there for a week or 2 weeks and having to be defined by the hospital-like regimen. However if I had to wake up every day knowing that this was my life, I could not begin to think about living in the future.

Frequently in our attempt to provide the right kind of services and to regulate, we find regulations leading to regimentation. It need not be so. I agree with the previous speakers who stated that without the regulations a most vulnerable population could be at the mercy of the marketplace. I am suggesting as an opening statement that we reorient our sights. Let us not reduce minimum requirements. Let us reduce requirements for inappropriate documentation and overzealous code application. Let us not look at the nursing home as another little hospital. Let us pretend we are going to look for a community to live in. When you go to relocate, what do you look for? You look for schools and shopping, cultural facilities, and the availability of medical care and availability of those services which will most directly meet the kinds of needs that you have as an individual. In the very same way we must look at nursing homes as long-term care communities. Let us look at them as a community of dynamics, not merely as a set of processes or set of regulated inputs. Is there space for life to develop both physically and emotionally? Are the resources in place? Are we something more than a mere medical facility?

It is possible to meet every regulation under medicare and medicaid and not be a facility of quality life. Conversely, it is possible not to meet all the regulations and be a facility where the quality of life is superior. We need to retrain the way we look at these facilities.

Jim Humbles alluded to my role in working to revise the medicaid reimbursement system in the State of Florida. I will not go into a long analysis of that. However, just as Federal tax policy induces certain kinds of economic behavior both on the part of individuals and on the part of the corporate community, so reimbursement policies induce behavior on the part of nursing home providers. Regardless of what regulations are written or outcomes requested, unless the reimbursement mechanisms are understood and tailored to help induce desired behavior, you may well end up with regula-

tions calling for one thing, while reimbursement penalizes the very thing the regs call for.

Both aspects, the desired outcomes and the nature of reimbursement policy, must be made to mesh.

I am ready for your questions

Senator HAWKINS. Thank you, Mr. Palevsky. I think you are right on target as we see the existing regulations stay in place. I do not know how long that will be. I still think we should examine what could be the optimum if we had the opportunity to rewrite them. There are too many of us who did not have input into those regulations in the first place. They may have been designed for one thing and resulted in another.

Do you think the Federal and State regulations have been effective in the areas to which they have been addressed?

Mr. PALEVSKY. I think over the past 10 years, really 8 years, care has improved because of the interest of the public sector which, by the way, is also the majority consumer of nursing home care.

Senator HAWKINS. Do you think there is a distorted regulatory emphasis on paperwork?

Mr. PALEVSKY. I think it is a distorted emphasis on documentation. There is a weird catch 22.

In my facility, in my "community," we have professional, social services, we have activities and we have physical and rehabilitation therapies. We have resident councils. We have many of the elements of good normal life processes. If we say we have it, then we must document it from A to Z. If we don't say we have it, we do not have to document anything, and we are still in compliance.

Now, that is a weird catch 22. If you do it, then you get nailed—not by it, but nailed to a cross of paperwork. Attendant to the services you provide and enhanced programing you undertake. If you do not claim anything beyond the very minimum required you have very little responsibility. The documentation requirements for certain aspects of those services that are defined as care need to be reexamined.

I do agree that in the application of medical treatment and medical therapy there must be full documentation. However, even here for treatments, medications, and therapies that will be maintained daily, perhaps for years, documentation should be by exception once the baseline is established.

Senator HAWKINS. The liability has been growing, so a lot of the paperwork has really arisen out of protection in some instances that——

Mr. PALEVSKY. Yes, but can you imagine having to document in your own life every step of your life process?

Senator HAWKINS. I read about it a lot.

Mr. PALEVSKY. In long-term care if you are trying to be a decent community and you are trying to make it possible for all kinds of life processes to occur, and you are responsible for those processes—can any of us sit down and try to document every input into our ongoing daily lives? We could either live vicariously through documentation or we could live through actual activity.

A nursing home administrator frequently finds himself in such a position or he has to double staff. He has to find one portion of staff to write and one portion of staff to do. Reimbursement will

not pay for both, but some administrators have to do it this way in order to meet all documentation requirement while maintaining quality programs and services.

Senator HAWKINS. Do you feel there is an inherent conflict between the provision of high quality services to the dependent elderly and profit maximization?

Mr. PALEVSKY. Yes.

Let me qualify that, however. I think among the very best nursing homes there are for-profit homes. Among some of the very poor nursing homes there are not-for-profit homes. However, structually there is an inherent conflict. Given limited resources and given limitless needs, clients in crisis, bed shortages and social values yet to be clarified, the marketplace cannot adequately determine or decipher what the need of a community is or the need of an individual is.

I think a much more appropriate model is one of community-based, and religiously or fraternally sponsored facilities. Particularly when government is the major purchaser of long-term care, how public funds are spent must remain a matter of public policy.

Let me give you a simple example of cost/care conflict. Let us say there is a 100-bed facility and its per diem rate is $30. Let us say $10 goes for real estate and other factors. $20 is left for care. Your per diem is known in advance, let us say. Let us say that 30 percent of the residents in that facility are incontinent beyond bowl and bladder rehabilitation and are not appropriate for catheterization. Let us say that these people need four, five, six, seven, eight changes of adult diapers and clothing per day. Each diaper itself will cost anywhere from 6 to 20 cents. Each change will take from 12 to 25 minutes with washup and cleanup. If your policy is change as needed, whenever the staff notices, that might increase overall costs for those 30 people for 365 days by $30,000 or $40,000, if you consider the staff time and supply cost.

If you are an operator and you are responsible to your stockholders, and are not responsible directly to the community, then you must decide, do you pay for the extra diaper and the extra 10 minutes or do you show a reasonable return to your investors. This is also your responsibility. I cannot tell you which way you should go. I do believe that in long-term care you should never have to face that conflict as an administrator. Fortunately, I do not have to.

Senator HAWKINS. Thank you so much. I know you have a plane to catch. I do not know how rushed you are, but do you think that the Federal Regs could be strengthened in any way, and then I will excuse you?

Mr. PALEVSKY. I think the Federal Regs should not be weakened. I think they need to be reoriented. I think the minimum requirements need to be there and strengthened. I think the processes by which they are examined and by which they are enforced needs to be reoriented.

Senator HAWKINS. We appreciate your participating here with us today, and want to keep in touch with you.

Mr. PALEVSKY. Thank you.

Senator HAWKINS. Dr. Pfeiffer, do you have a statement, or would you just like to have some questions?

STATEMENT OF ERIC PFEIFFER, M.D., DIRECTOR, SUNCOAST GERONTOLOGY CENTER, TAMPA, FLA.

Dr. PFEIFFER. I have a statement, which I would like to see incorporated in the record. It is a bit lengthy, but I would like to summarize some opening remarks.

Senator HAWKINS. Fine.

Dr. PFEIFFER. I come at this from a somewhat different perspective, Senator Hawkins, from the university perspective. It is only very recently that universities have gotten involved in the issue of long-term care. I think this is entirely appropriate. I think we have gotten involved in this because of two major changes that have happened. One I will call a demographic imperative. I think this relates to the demographics of our population as a Nation, but particularly in the State of Florida.

In the United States, the population of elderly has roughly doubled between 1950 and 1980, going from 12 to 25 million. In the State of Florida the population of elderly has roughly increased by sixfold from 1950 to 1980, from 237,000 to 1.68 million at this time.

In our four-county area in which we are currently holding this hearing, the increase has been approximately twelvefold over that same 10-year period, with several of the counties having increases of 15 to 20 times the population of elderly, particularly in the surrounding counties. Because of this, both the university medical school located in this geographic area and the National Administration, both the current administration and the preceding administration, I think found that it was necessary to address long-term care as an intellectual issue and to try to rethink the system of long-term care.

Added to this demographic imperative, I think, has come the issue of a fiscal imperative. When we examine the national expenditures from the public funds for long-term care, particularly nursing home care, we see essentially a runaway increase at an annual rate of 22 percent over the past 10 years, which in a compounded fashion will run us out of money in the public purse. So, I think we have added to the demographic imperative a fiscal imperative to reexamine the system of long-term care.

A third imperative I think we have heard a great deal of documentation on today already, and that, I think, is the human imperative of what it is like to be living in a long-term care system. I would just like to say a few words about how we approach the issue of long-term care.

First of all, we feel some definitions of long-term care are in order. Much of the discussion has focused on nursing homes, but, in our view, long-term care is a broader issue than that and it includes earlier forms of intervention. In fact, it includes the entire range of health and social services provided to individuals who have lost the capacity for independent living due to chronic physical or mental illnesses. It includes the nursing homes, but it includes a broader range of services. In our view, the system needs overhauling on a systemwide basis rather than on merely an incremental basis.

The focus and purpose of the long-term care centers is to seek to bring about some improvement and changes in the system of care.

Some of our issues in particular are related to the need to look at regulations not only of nursing homes, but to bring in such questions of whether we need to emphasize earlier aspects of care that still find the patient in the community. With this in mind, we have developed a model of care that I think we need to examine further. This model is included in the material that is available to you.

I will be talking about long-term care services, which are our most expensive services and which we are spending the largest amount of public dollars in. There should be greater emphasis on devoting public dollars to the active rehabilitation and treatment of elderly patients who are beginning to develop chronic illnesses and to the prevention and health promotion services. We also need to look at nonservice provider issues, such as tax changes that might allow individuals to stay in their own home for a longer period of time.

I think we need to address the whole issue of care to maintain older people who come to this State and to maintain them longer prior to needing long-term care. In the specific area of nursing homes, we would like to make only two or three major recommendations that I would like to lay at your feet in terms of possible changes in regulation.

We would like to recommend a mandatory preadmission assessment for all admissions to nursing homes, public or private.

Second, we would like to include in public regulations of nursing homes training of all personnel, both administrative, nursing, and all the way down to the care givers at the hands-on level, to professionalize the long-term care system rather than to see it simply as a business. Also, we need to focus on the joint involvement of both the health and social service professionals, not only in acute care but in long-term care.

I would be glad to respond to your questions now.

[The prepared statement of Dr. Pfeiffer follows:]

THE UNIVERSITY OF SOUTH FLORIDA

SUNCOAST GERONTOLOGY

CENTER

A PART OF THE NATIONAL NETWORK
OF LONG-TERM CARE CENTERS

MATERIALS SUBMITTED IN SUPPORT
OF TESTIMONY GIVEN BY
ERIC PFEIFFER, M.D., DIRECTOR
USF SUNCOAST GERONTOLOGY CENTER
AT A HEARING HOSTED BY
U.S. SENATOR PAULA HAWKINS
ST. PETERSBURG, FLORIDA, MARCH 1982

INTRODUCTION

The purpose of the material to follow is to provide key persons involved in the shaping of national policy regarding the aged with a brief overview of some of the factors which have led to the development of a national network of long term care centers. In addition, the material serves to acquaint these key persons with the scope and significance of programs and activities of the University of South Florida Suncoast Gerontology Center (SGC) which forms a part of this national network.

The material is arranged so as to closely resemble the stages of development of the long term care centers network and more specifically the Suncoast Gerontology Center. The first section provides a brief discussion regarding the demographic and fiscal imperatives which have and continue to generate interest and involvement in long term care. The second section describes the national network of long term care centers. In the third section, specific discussion is provided regarding the development, structure, and mission of the Suncoast Gerontology Center. The fourth and final section provides a relatively detailed discussion of the major programs of the Suncoast Gerontology Center.

Should you have any specific questions regarding the material contained herein or any other inquiry regarding the Center, please do not hesitate to contact any of the following persons at (813) 974-4355:

Eric Pfeiffer, M.D., Director
Esther S. Kleine, M.A., Assistant to the Director
Patricia Barry, M.D., Clinical Services Coordinator
Richard Cairl, Ph.D., Research Coordinator
J. Neil Henderson, Ph.D., Education and Training Coordinator

1. Demographic and Fiscal Imperatives for long Term Care

A. Demographic Imperative: Past, Present, Future

Since approximately 1950, the growth of the population cohort 65 years of age and over in the U.S., and more particularly Florida, has been dramatic. This massive growth in the aged population has prompted contemporary observers to articulate what is now rather commonly referred to as a "demographic imperative". Simply stated, the imperative stresses that with the tremendous growth in the aged population relative to the population as a whole, there has emerged a concomitant and heretofor unexperienced challenge to understand the unique problems of the aged in society and to satisfy the multidimensional nature of their needs. In effect, the problems of the aged have, in recent decades, come of age in a complex society.

In an effort to briefly, and somewhat abstractly demonstrate the challenge of this demographic phenomena and its implications, Tables 1-8 provide information regarding the past, present and projected statistical patterns of growth of the aged population in the U.S., Florida, and the Tampa Bay Area. The highlights of these statistical patterns are as follows:

- Between the years 1950 and 1980, the proportion of the population 65 years of age and over in the U.S. has remained relatively stable, representing in 1980 approximately 11.3% of the total population. In contrast, in Florida, and more specifically, the Tampa Bay Area (consisting of Hillsborough, Manatee, Pasco, Pinellas counties) this proportion has, over the same period, approximately doubled. (Table 1)

- Within the Tampa Bay Area the most dramatic growth in the 65+ population relative to the total population, has ocurred in Manatee, Pasco, and Pinellas counties, with the proportion in Hillsborough county approximately the same proportion as the nation. (Table 2)

- The decennial percentage increase in total U.S. population over the period 1950-1980 was approximately 50 percent. During the same period, the percentage increase for the 65+ population was over 100 percent. (Table 3)

- The decennial percentage increase in the total population of Florida over the period 1950-1980 was five times greater than that of the nation as a whole. More dramatically, the 65+ population of Florida during this same period increased over 600 percent. (Table 3)

- Within the four county area comprising Tampa Bay, the decennial percentage increase in the 65+ population over the period 1950-1980 was, with the exception of Hillsborough county, greater that the nation as a whole, with Pasco County experiencing a tremendous 709 percent increase. (Table 4)

- Based upon conservative projections the proportion of the total population 65 years of age and over in the U.S., Florida, and Tampa Bay Area for the year 2000 will be approximately the same as 1980, with the proportion in Florida and the Tampa Bay Area approximately double that of the nation. (Tables 5 and 6)

- The percentage increase in the numerical growth of the 65+ population between the period 1980-2000 in the U.S. will be approximately 25 percent. In Florida this percentage increase will be considerably greater than the nation as a whole with approximately a 50 percent numerical increase in the Tampa Bay Area, supporting by the year 2000 over one-half million persons 65 years of age and over. (Tables 7 and 8)

TABLE 1

Population 65 and Over as a Percent of the Total Population for the U.S., Florida and the Tampa Bay Area Based on Census Counts for 1950, 1960, 1970, 1980(1)

	1950	1960	1970	1980
U.S.				
Total pop.	150,697,000	179,323,175	203,235,298	226,504,825
65+	12,362,000	16,560,000	19,972,000	25,500,000
% of total	8.2	9.2	9.8	11.3
Florida				
Total pop.	2,771,305	4,951,560	6,791,418	9,739,992
65+	237,474	553,129	989,366	1,684,972
% of total	8.5	11.2	14.6	17.3
Tampa Bay Area(2)				
Total pop.	464,376	878,406	1,185,664	1,717,934
65+	57,288	154,821	258,461	376,731
% of total	12.3	17.6	21.8	21.9

[1]Data for generating the above table were extracted from:

Older People in Florida - A Statistical Abstract. Bureau of Economic and Business Research, Center for Gerontological Studies. Gainesville: The University Presses of Florida, 1981.

[2]Tampa Bay area includes Hillsborough, Manatee, Pasco, Pinellas counties.

TABLE 2

Population 65 and Over as a Percent of the Total Population for Hillsborough, Manatee, Pasco and Pinellas Counties Based on Census Counts for 1950, 1960, 1970, 1980(1)

	1950	1960	1970	1980
Hillsborough County				
Total pop.	249,894	397,788	490,265	646,960
65+	20,127	39,125	51,186	74,313
% of total	8.0	9.8	10.4	11.5
Manatee County				
Total pop.	34,704	69,168	97,115	148,442
65+	4,728	15,192	29,331	40,156
% of total	13.6	22.0	30.2	27.1
Pasco County				
Total pop.	20,529	36,785	75,955	194,123
65+	2,497	7,342	24,021	59,437
% of total	12.2	19.9	31.6	30.6
Pinellas County				
Total pop.	159,249	374,665	522,329	728,409
65+	29,936	93,162	153,923	202,825
% of total	18.8	24.9	29.5	27.8

[1]Data for generating the above table were extracted from:

Older People in Florida - A Statistical Abstract. Bureau of Economic and Business Research, Center for Gerontological Studies. Gainesville: The University Presses of Florida, 1981.

TABLE 3

Decennial Percentage increase in Total Population and Population 65 Years and Over for U.S., Florida, and Tampa Bay Area: 1950 - 1980(1)

	Total Population			Population 65 and Over		
	Number	Percent Increase from Preceding Decade	Over Period 1950-80	Number	Percent Increase from Preceding Decade	Over Period 1950-80
U.S.						
1950	150,697,000	14.5	50.3	12,362,000	37.3	106.3
1960	179,323,175	18.9		16,560,000	34.0	
1970	203,235,298	13.3		19,972,000	20.6	
1980	226,504,825	11.3		25,500,000	27.7	
Florida						
1950	2,771,305	46.6	251.4	237,474	81.0	609.5
1960	4,951,560	78.6		553,129	132.9	
1970	6,791,418	37.2		989,366	78.9	
1980	9,739,992	43.4		1,684,972	70.3	
Tampa Bay Area (2)						
1950	464,376	(3)	270.0	57,288	(3)	557.6
1960	878,406	89.2		154,821	170.3	
1970	1,185,461	35.0		258,461	66.9	
1980	1,717,934	60.6		376,731	45.8	

[1] Data for generating the above table were extracted from:

Older People in Florida - A Statistical Abstract. Bureau of Economic and Business Research, Center for Gerontological Studies. Gainesville: The University Presses of Florida, 1981.

[2] Tampa Bay Area Includes Hillsborough, Manatee, Pasco, and Pinellas counties.

[3] 1940 Census counts by county unavailable

TABLE 4

Decennial Percentage Increase in Total Population and Population 65 Years and Over for Hillsborough, Manatee, Pasco, and Pinellas Counties: 1960 - 1980(1)

	Total Population			Population 65 and Over		
	Number	Percent Increase from Preceding Decade	Over Period 1960-1980	Number	Percent Increase from Preceding Decade	Over Period 1960 - 1980
Hillsborough						
1960	397,788	59.2	62.6	39,125	94.4	89.9
1970	490,265	23.2		51,186	30.8	
1980	646,960	32.0		74,313	45.2	
Manatee						
1960	69,168	99.3	114.6	15,192	221.3	164.4
1970	97,115	40.4		29,331	93.1	
1980	148,442	52.8		40,156	36.9	
Pasco						
1960	36,785	79.2	427.7	7,342	194.0	709.5
1970	75,955	106.5		24,021	227.2	
1980	194,123	155.6		59,437	147.4	
Pinellas						
1960	374,665	135.3	94.4	93,665	212.9	116.5
1970	522,329	39.4		153,923	64.3	
1980	728,409	39.4		202,825	31.8	

[1]Data for generating the above table were extracted from:

Older People in Florida - A Statistical Abstract. Bureau of Economic and Business Research, Center for Gerontological Studies. Gainesville: The University Presses of Florida, 1981.

TABLE 5

Projections of the Total Population and Population 65 Years and Over for U.S., Florida and the Tampa Bay Area: Year 2000 (Projections based upon July 1, 1979 population estimate)(1), (2)

	Total Projected Population (Yr 2000)	Projected 65+ Population (Yr 2000)	Projected 65+ as a % of total
U.S.	282,837,000	31,822,000	11.25
Florida	13,624,100	2,356,969	17.3
Tampa(3) Bay Area	2,479,300	550,280	22.2

[1]NOTE: Projected totals for U.S. based upon 1976 estimate.

[2]Data used to construct the above table were extracted from:

a. U.S. Bureau of the Census, Current Population Reports, Series P-25, 1980.

b. Florida Statistical Abstracts, Bureau of Economic and Business Research, Population Studies Section, University of Florida. 1980.

[3]Tampa Bay Area includes Hillsborough, Manatee, Pasco and Pinellas counties.

TABLE 6

Projections of the Total Population and Population 65 Years and Over for Hillsborough, Manatee, Pasco and Pinellas Counties: Year 2000 (Projections based upon July 1, 1979 population estimates)(1)

	Total Projected Population (Yr 2000)	Projected 65+ Population (Yr 2000)	Projected 65+ Population as a % of total
Hillsborough County	900,100	104,411	11.6
Manatee County	217,400	58,698	27.0
Pasco County	306,800	93,881	30.6
Pinellas County	1,055,000	293,290	27.8

[1]Data used to construct table above were extracted from Florida Statistical Abstracts, Bureau of Economic and Business Research. Population Studies Section, University of Florida (1980).

TABLE 7

Percentage Increase in Population 65 Years and Over for U.S., Florida, and Tampa Bay Area: 1980-2000.(1), (2)

	65+ Population (1980)	Projected 65+ Pop. (2000)	Percent Increase
U.S.	25,500,000	31,822,000	24.8
Florida	1,684,972	2,356,969	39.9
Tampa Bay Area[3]	376,731	550,280	46.1

[1]Projections based upon July, 1979 estimates

[2]Data used in generating the above table were extracted from:

a. U.S. Bureau of the Census, Current Population Reports, Series P-25, 1980.

b. Florida Statistical Abstracts, Bureau of Economic and Business Research, Population Studies Section, University of Florida. 1980.

[3]Tampa Bay Area includes Hillsborough, Manatee, Pasco, and Pinellas counties.

TABLE 8

Percentage Increase in Population 65 Years and Over for Hillsborough, Manatee, Pasco, Pinellas Counties: 1980 - 2000(1), (2)

	65+ Population	Projected 65+ Population (2000)	Percent Increase
Hillsborough County	74,313	104,411	40.5
Manatee County	40,156	58,698	46.2
Pasco County	59,437	93,881	58.0
Pinellas County	202,825	293,290	44.6

[1]Projections based upon July 1979 estimate

[2]Data used in generating the above table were extracted from:

Florida Statistical Abstracts, Bureau of Economic and Business Research, Population Studies Section, University of Florida, 1980.

B. Fiscal Imperative: Re-Thinking the long Term Care System

Concomitant with the demographic pattern in the aged population, there has been a corresponding growth in the fiscal expenditures for the provision of services to the elderly. As an example of this growth, Table 1, below provides a capsule summary of the increase in nursing home expenditures for the period 1950-1979.

Table 1:

Dollar Amount ($) and Percentage Distribution of Nursing Home Care Expenditures Relative to Total National Health Expenditures in the U.S. for the Period 1950-1979. (1)

	YEAR (in millions)				
	1950	1960	1970	1979	%Increase (1950 - 1979)
$ Amount	187	526	4,697	17,807	9,738.0
% of Total National Health Expenditures	1.5	2.0	6.3	8.4	6.9

(1) SOURCE: "National Health Expenditures, 1979." Health Care Financing Review, 1980: 1-36.

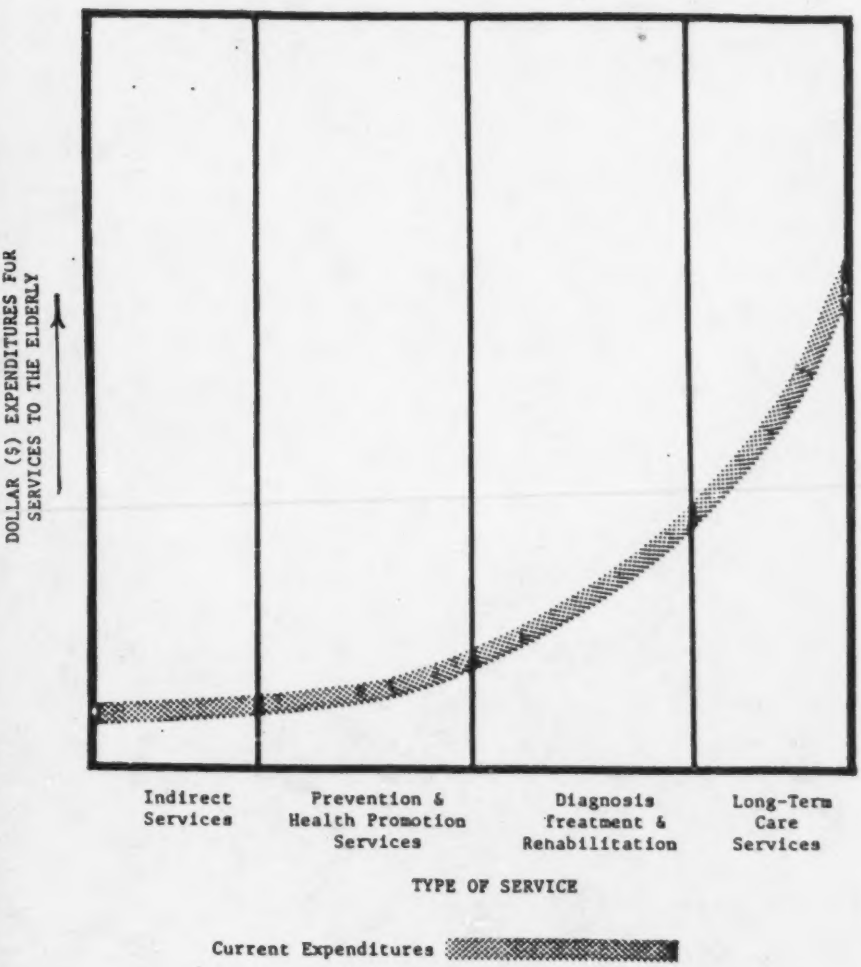
The Figures displayed in Table 1, clearly indicate that the growth of expenditures for nursing home services have increased at a geometric rate. Moreover, they imply that unless this geometric progression is abated, nursing home care, which conceptually represents only one component of the long term care system, will absorb a major proportion of the public and private dollars expended for total health services. Indeed, some experts suggest that by the year 1980, nursing home expenditures alone will reach 76 billion dollars, representing 14.0 of the total projected national health expenditures. Of this amount, approximately 48.0 percent will be paid through public program dollars.

Although the meaning of the fiscal imperative is reasonably clear from the brief data provided above, the prognosis need not be so pessimistic. Several observers of the long term care system have suggested that there has been a fundamental bias in the system towards institutionalization. That, in effect, a large proportion of elderly persons who have been and currently are in nursing homes (Skilled Nursing Facilities; Intermediate Care Facilities) , are inappropriately placed. This condition or bias has resulted from 1) a rather ubitquitous assumption that nursing home care (or institutionlization) is the proper setting for dealing with the problems of the moderate to severely impaired elderly and, 2) only marginal emphasis in the past to design, implement and evaluate alternative and less costly service models and programs which could (would) insure a better fit between the needs of the elderly person and the service or services to satisfy these needs.

Figure 1 below provides a graphic example of the pattern of existing expenditures for various types of services to the elderly with the current bias of institutionalization operating. The trend line serves to indicate that the largest proportion of fiscal expenditures along the continuum of services for the elderly are absorbed by long term care services - i.e. nursing home care. Moreover, the trend line travels a projectile which is consistent with the actual fiscal patterns displayed in Table 1 above.

Figure 1

GRAPHIC TREND IN PAST AND CURRENT EXPENDITURES FOR VARIOUS TYPES OF SERVICES TO THE ELDERLY

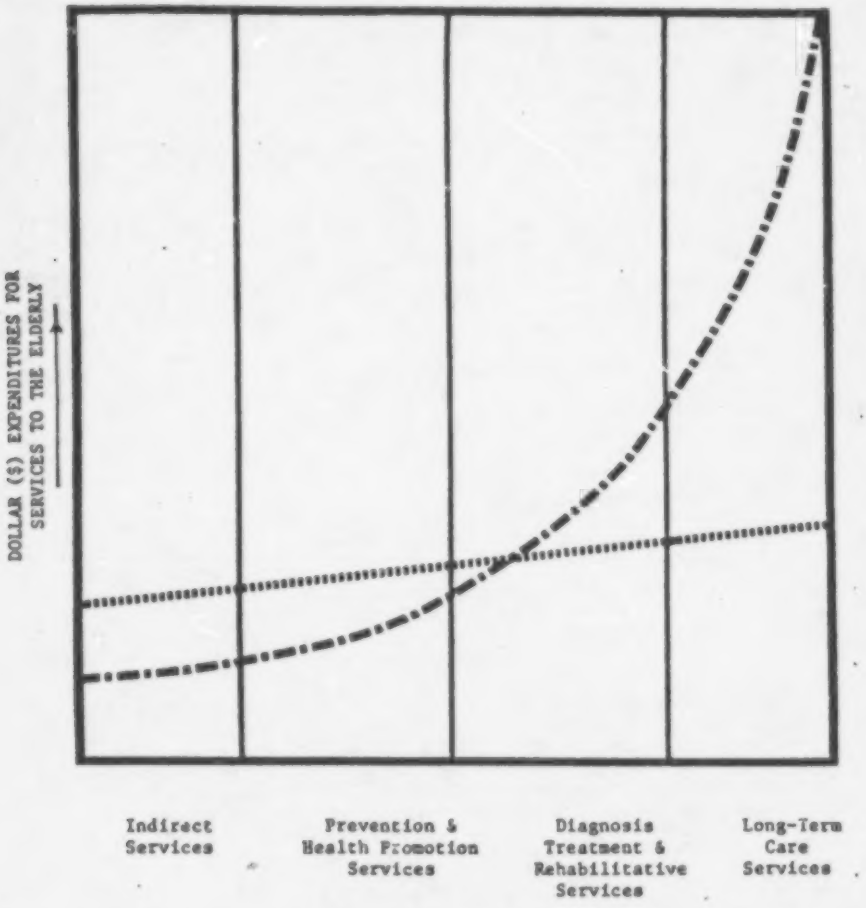


As an alternative to the pattern displayed in Figure 1, Figure 2 graphs the potential projected change in current expenditure patterns with greater emphasis being placed upon the entire continuum of services for the aged to include indirect and prevention and promotion services. The logic of this graphic display is rather straightforward. If model services and programs are developed which promote early detection and treatment of the physical, psychological, and social problems and needs of the elderly community, then there will be a corresponding decrease in the proportion of that community who will require long term care for chronic conditions in nursing homes, and/or other institutional settings.

Basically, the Long Term Care Centers Network emerged in response to the demographic and fiscal imperatives briefly discussed above. The material to follow describes this network with specific attention placed upon the activities and programs of the Suncoast Gerontology Center.

Figure 2

PROJECTED GRAPHIC TREND IN EXPENDITURES FOR VARIOUS TYPES OF SERVICES TO THE ELDERLY BASED ON ALTERNATIVE FUNDING OPTIONS


DOLLAR ($) EXPENDITURES FOR SERVICES TO THE ELDERLY
Indirect Services
Prevention & Health Promotion Services
Diagnosis Treatment & Rehabilitative Services
Long-Term Care Services
TYPE OF SERVICE
Projected Expenditures Based on Alternative Funding Policies
Projected Expenditures Based on Current Funding Policies

2. History of the Long-Term Care Centers Nationally

The establishment of Multidisciplinary Centers of Gerontology was authorized by Title IV-E of the Older Americans Act as amended in 1978 in response to a growing national concern about issues of LTC as they relate to the demographic and fiscal imperatives discussed above. The long-range objective of this AoA funded program was to develop a network of comprehensive long-term care gerontology centers which will function as a national resource for:

- educating and training health and social service personnel to meet the needs of the functionally impaired elderly
- developing and testing of models of health care and social services that will enable this group of elderly to remain in the least restrictive setting possible
- developing a knowledge base in long term care through conduct of interdisciplinary research
- providing information and technical assistance on long-term care issues and problems to regional and national agencies, academic institutions, policy makers and providers of services

The issues which these AoA funded Centers are expected to address are multiple and complex. They are based on a system of "long-term care" which HCFA in a recently published discussion paper defined as " a range of medical and supportive services for individuals who have lost some capacity for self-care due to a chronic illness or condition and who are expected to need care for an extended period." Such factors as the projected increase in the number of elderly above the age 75, the longer life expectancy of the disabled, and the inflation of nursing home, home health care, and personal care costs make it increasingly difficult to maintain the security of those in need of long-term care services.

The Centers, in concert with other state and local programs are focusing on these issues in order to assure the quality of care and quality of life of the long-term care population - both in institutions and in the community. Creative solutions to the problem of providing and financing long-term care must be developed which acknowledge the desire of people to be independent and productive for as long as possible.

Although still in early stages of development and operation, the LTC Centers have begun to make significant contributions toward the field of long-term care. They are providing technical assistance to a wide range of long term care providers and agencies as well as assisting directors of State and Area Agencies on Aging and administrators of State Departments of Health and Social Services to develop service systems that would improve care of the functionally impaired elderly. In other instances they are working with local senior center advisory councils, congregate living facilities, and volunteer organizations to improve coordination of services.

Centers are also becoming a valuable resource for state legislators and other policy makers by responding to requests for information from these groups on an ad hoc basis, by conducting state-wide surveys to identify unmet service needs among the elderly population, and by developing recommendations for long-term care that could be incorporated into state legislation. Results of policy research conducted by the centers have been used in developing effective long term care policies.

Geographic Distribution of the Long-Term Care Centers

There are now nine operational Long-Term Care Gerontology Centers nationally. The nine are the Suncoast Gerontology Center for Health and Long Term Care, University of South Florida College of Medicine, Tampa, Florida; The Center for Geriatrics and Gerontology/Long Term Care, Faculty of Medicine, Columbia University, New York City, New York; The Southwestern New England Long Term Care Gerontology Center, Brown University Division of Biology and Medicine, Providence, Rhode Island; the UCLA/USC Long Term Care Gerontology Center, The University of California, Los Angeles, California; The University of Washington Long Term Care Gerontology Center, Seattle, Washington; The University of Arizona Long Term Care Gerontology Center, Tucson, Arizona; The Milwaukee Long Term Care Gerontology Center, Milwaukee, Wisconsin; the University of Kansas Long Term Care Gerontology Center, Kansas City, Kansas; and Temple University Long Term Care Gerontology Center, Philadelphia, Pennsylvania.

LONG TERM CARE GERONTOLOGY CENTERS

3. University of South Florida as a Site: The Suncoast Gerontology Center

On July 1, 1980, the University of South Florida, located in Tampa, Florida established the Suncoast Gerontology Center for Health and Long Term Care. The mission of the Center is to establish at the University of South Florida, in the midst of one of the nation's highest concentrations on elderly, a center of excellence in the field of health, social and community services, as they relate to the long-term care of the frail and the functionally impaired elderly.

The Center serves as a regional and, in collaboration with other Centers, as a national resource on long-term care. By providing an integrated set of programs in a) education and training, b) innovative clinical services, c) applied and policy research, d) technical assistance, and e) public information, the Center intends to function as a change agent to the existing system of long-term care, with the goal of improving the level of functioning and the quality of life of older persons.

A. Education and Training:

Improving training and education of students from a variety of disciplines who will work in the field of health and long-term care or professionals who are now working with the elderly.

This is accomplished by:

- training programs for specific types of professionals such as doctors, nurses, social workers, etc.
- workshops and conferences for persons currently working with the elderly
- technical assistance to private and public agencies
- public information programs about the aging process to educate the elderly, their relatives and the general public.

B. Innovative Clinical Services:

Developing, implementing and testing new service models and improving existing practice programs in long term care for the elderly. This includes:

- early intervention - prevention, health education and self-care programs
- comprehensive assessment, case management, follow-up reassessment and design of individual treatment plans of multiply impaired elderly
- care of the care-giver programs to avoid or reduce institutionalization of impaired elderly.
- improving existing programs within the long term care system with a focus on excellent medical and psychiatric care, retraining of activities of daily living and social competency skills, as well as other rehabilitative measures.

C. Applied and Policy Research:

Developing an interdiciplinary research program directed toward the theoretical and practical understanding of the health, social, and long-term care needs of the elderly.

This is accomplished by:

- the development of a comprehensive data base on the health status and the health and social service needs of the elderly
- the development and implementation of methods for evaluating all clinical services and educational programs of the Center
- research on specific illnesses, treaments, and service delivery methods related to the health and long-term care needs of the elderly
- research on policy issues as they relate to long-term care

D. Technical Assistance:

Implementing programs of technical assistance to private and public agencies in the field of long-term care. This includes not only local service providers, but also state offices and area agencies on aging throughout this region. Technical assistance is provided through consultations by one or more center staff member in the form of individual counseling and/or workshops on issues related to long term care, health and aging. Technical Assistance also includes the Center's role as a broker of technical assistance resources (see also TA program details following section 5). All TA efforts have a dual function in their simultaneous information dissemination and service provision.

E. Public Information Programs:

Implementing public information programs about the aging process and long- term care to elderly persons themselves, to their relatives, and to the general public.

This is accomplished by:

- conferences open to the public and to specified lay and professional audiences
- workshops which are specialized functions of conferences or stand as independent projects
- television, radio, and newspaper coverage of prominent events and speakers of the SGC
- the Suncoast Gerontology Center Library is a carefully selected repository of scientific gerontological data in book, journal, and audio/visual formats. Materials are available for use on the premises.
- books containing information on aging addressed to both lay and professional audiences.

4. Center Programs

Center activities are undertaken not by individuals or by Center divisions but are Center- wide. This means that programs are constellations of activities on a common topic. Center Programs each have all of the following dimensions or characteristics: 1) a knowledge base; 2) a model services component; 3) a teaching component; 4) a research component; 5) a product or products to be generated. The fruits of these programs are available for dissemination both through technical assistance and through public information efforts.

In developing the programs described, a framework of assumptions was established which acknowledges several important truths about a service system design for the elderly:

- a full range of services must be available to all the elderly to meet the changing needs of this segment of our population.
- each type of service has specific costs, public or private, associated with it.
- current trends in service delivery, if continued without modification into the future, are fiscally alarming, especially in an era of static or even shrinking public resources.
- modifications in the availability of certain types of services, when judiciously pursued, may obviate the need for other services.
- shifts in policy to emphasize availability of certain types of services now may alter the need for other types of services later, with important cost-saving implications.
- shifts in policy to emphasize alternative types of services would be more responsive to realistic needs of the majority of elderly, thereby improving their functioning capacity and maximizing their abiility to live independently.

The following roster and detailed description of Suncoast Gerontology Center programs do not constitute a rigid statement of operational components. Additional activities may be initiated or may evolve depending on national, regional and local needs, while others may be phased out. However, these programs represent the major issues which the Center wants to address over a period of three to five years:

1. Service System Development
2. Technical Assistance
3. Public Information
4. Prevention, Early Intervention and Health Promotion
5. The Teaching Nursing Home Program
6. Dementia — "Understanding and Coping with Dementia"
7. Resource Development Program
8. Interdisciplinary Training
9. Continuum of Services
10. Pre-Nursing Home Assessment and Assessment Methodology

On the following pages, each one of these programs is described in detail.

1. Service Systems Development Program

The Center's Service System Development Program is, in many respects, an umbrella program which provides the conceptual framework for the other nine proposed programmatic activities. The concept "system" refers to the set of organizational components which comprise a continuum of medical, psychiatric, social and behavioral services for the elderly and to the formal and informal relationships which tie them together. These components consist of broad categories of services ranging from indirect services to long-term care services, as previously discussed in our theoretical model. The goal of the program is to examine the existing system of services and to stimulate the conceptual development and testing of new service models which, it is hoped, are more highly responsive to the entire range of service needs of the elderly as well as to fiscal, especially cost containment, issues.

The program will consist of the following projects:

a. Study of the Current System: As a starting point for systems development this project will examine the current service system utilizing the Tampa Bay area as an example of service systems nationally. The specific questions to be addressed include the following:

(1) To what extent does the existing system reflect the continuum of services identified in the theoretical model? (e.g., what is the proportion of various types of services available in the community?)

(2) What are the gaps and duplications of services?

(3) What interorganizational linkages exist and what problems or benefits result from such linkages?

Concomitant with the examination of a community based service system, efforts will be made to delineate the national service system and to determine the way in which the national and the area system differ. We feel that a thorough understanding of the current system of services is a necessary basis for developing alternative service systems.

b. Service System Development Policy Seminar: The purpose of this project is to identify policy issues and to stimulate creative thinking concerning new approaches to service delivery. Topics in the seminar series will range from those emphasizing broad conceptualizations of service models to those which examine specific political, social, and economic feasibility of new components to an overall service system. It is expected that this activity will result in the development of one or more alternative models of service systems for the elderly.

The seminar will be a continuing one. Begun in November of 1981, the seminar will meet on a fortnightly basis. It will be jointly led by Drs. Pfeiffer, Rich, and Cairl and will be open to all Center staff, faculty from other departments and colleges within the university and the medical school community and to representatives from various service organizations with interests in service system development.

c. Policy Papers: The value of the conceptual and analytical effort put forth in this program area can only be fully realized if these efforts are transformed into concepts and/or position papers for review and response by others. As such, a major project in the systems development program will be to produce, on an episodic basis, a series of policy papers on specific topics relevant to service system development. These policy papers will be distributed to local, state, and federal agencies as well as to professional associations and organizations. The Center has committed itself to deliver the first of these policy papers at the April 1982 meeting of the National Council on the Aging (NCOA) on the topic of "Re-examining the System of Long-Term Care," with others to follow.

d. Cost Studies: The purpose of this project will be to examine the implication of alternative system models in terms of cost. The cost studies to be performed will include not only commonly used cost-estimating techniques but will also make use of computer simulation models. The Center has access to expertise on simulation models and to computer hardware and software designed for simulation planning. Simulation planning has the advantage of being able to give rapid responses as well as to handle sizeable numbers of corrected changes simultaneously, rather than having to wait for one or more "natural experiments" or for multi-year studies of policy changes and demonstration projects.

The results of these cost studies will be disseminated to program and policy specialists at the local, state and federal level.

e. Feasibility Study of Systems Change: During the last six months of the next budget period the Center will undertake a feasibility study of systems change in the local community in the Tampa Bay area. This project represents an attempt to examine the political, social, and economic feasibility of introducing a comprehensive new service system into a community. The feasibility study will address the following questions:

(1) What are the political barriers to systems development and change?

(2) What action steps or strategies are necessary and effective in facilitating systems change?

(3) What are the appropriate change agents and their respective roles in bringing about systems change?

Again, results of the feasibility study will be made available to the local, state, and federal respresentatives as well as to professional organizations. It is hoped that the study will achieve some understanding if not wisdom, concerning the complexities of effecting systems changes from a community perspective.

2. Technical Assistance Program

The role which the Suncoast Gerontology Center has played in the area of providing technical assistance thus far has been two-fold: First,the Center has been used as a local resource with a capacity to assist public and private organizations, area agencies on aging and Florida state program offices in areas of training, research and service system development. Second, the Center has, individually and by way of its partnership with other operational Centers, seen itself as a national resource, contributing to the shaping of policy issues of health and social services for the elderly.

To these two components, a third will be added which will focus on technical assistance to all the states throughout this HHS region. The expertise and skills of all Center professionals and Center affiliated personnel will be made available for this effort. Ms. Esther S. Kleine, Assistant to the Director will devote 50% of her time to serve as Technical Assistance Coordinator for the Center.

Action steps to accomplish this objective are as follows:

a. Establish Contact with and communicate TA role of the SGC to the appropriate agencies and state offices throughout the region. This will involve a visit of two staff members to each of the state offices.

b. Conduct a Technical Assistance Needs Assessment involving all sites with the goal of identifying the type and scope of assistance desired. The specific and general areas of expertise available through the SGC will have been announced in order to facilitate a better response to the needs assessment.

c. Negotiate Concrete TA Products and Methods to be used with the site staff. Responsibilities of Center and TA site staff as well as a specific time frame for completion will be agreed upon.

d. Actual Provision of T.A. and documentation of any deviations from the orginial plan and results or products for future reference.

e. Perform T.A. "Brokerage" Role: Whenever possible, and especially in the case of internal limitations, the Center will play the role of a "resource broker." In addition to the needs assessment, the TA Coordinator will initially establish a "resource bank" by exploring and listing areas of technical and programmatic expertise within the various state offices and agencies. Pooling and brokering these resources will have an exponential effect on the exchange of ideas between the states. It will influence innovative program development and thereby improve the health and social service system for the elderly in this region.

3. Public Information Program

Center staff are ever mindful of the fact that the Center exists for the benefit of older Americans. Accordingly, a major effort of the Center is devoted to getting into the hands of the public but especially into the hands of older persons themselves and their families usable and reliable information about the aging experience, hazards, complications, opportunities and rewards. We also wish to disseminate usable and reliable information about available indirect, preventive, treatment, rehabilitative, and long-term care services as well as to call attention to opportunities for older persons to serve. While "public information" is to a significant degree the responsiblity of all Center staff, especially its Director and Executive Committee, specific responsibility for public informational programs is assigned to Ms. Johanna Newton (Public Information Specialist/Resource Librarian) and to Dr. Neil Henderson, Education and Training Coordinator. The Center is also assisted in this task by Ms. Nancy Ford, the Medical Center's Public Information Officer and Mr. Joe Busta, the University's Information Director. The Public Information program consists of the following components:

a. Center Newsletter: The Suncoast Gerontology Center was the first of the operational centers to publish a newsletter on Center programs and activities, and has been pleased that this practice has been followed by several other centers. The newsletter, AGING INFORMATION, is provided at no cost to interested professionals and members of the public on a quarterly basis.

b. Resource Library: A resource library on health and long-term care has been established at the Center. It houses a growing number of books, journals, reprints, video and audio tapes. Some of these are geared to professionals while others are addressed specifically to a lay audience. The library has a capacity to conduct both manual and computer searches on specific topics, and publishes and distributes bibliographies on selected topics from time to time. A recent development is a special subsection of the library which contains materials for lay people on Alzheimer's Disease and which is staffed by a volunteer librarian who is a member of the Center's Alzheimer's Disease Support Group (see Dementia Program below). The resource library is also the repository of the Center's "Speaking on Aging" video tape series of interviews by the Center Director with experts in the field of aging. Thus expert visitors to the Center are permanently "captured" by the Center for later teaching use.

c. Public Forums: In March of 1982 the Center will initiate a series of bimonthly forums on health and social service issues of importance to the elderly. This series will use Center and Center-affiliated personnel to provide easily understood and practical information to elderly persons and their families residing in the Tampa Bay area. The content of these presentations will be captured in a handbook, ISSUES IN AGING, which can serve as a guide to mounting such public forum series in other communities.

d. Radio and Television Appearances and Speaker's Bureau: All professsional Center staff are ready, trained, and experienced in radio and T.V. appearances on the topics of their expertise to further the public information effort of the Center. In addition, the Center is responsive to requests for speakers on topics related to services for the elderly from service clubs and organizations such as Rotary, Kiwanis, Chamber of Commerce, Governor's Conference on Aging, and so on. During the past year Center staff logged over 100 such appearances on a broad range of topics related to the service delivery system for the elderly.

e. Community Conferences: Information about aging and all the substantive issues previously described will continue to be offered through workshops and conferences held at the Suncoast Geontology Center. These conferences will not only be accessable to professionals in the field of gerontology/geriatrics but to older persons themselves and their families. Please refer to sections 7 and 8 for additional information on conferences.

4. Prevention, Early Intervention and Health Promotion Program

The Center's Prevention, Early Intervention and Health Promotion Program consists of a number of linked projects which for the most part are a direct response to the Commissioner's call for a broadened mission for the long-term care gerontology centers. Some elements of this program, however, are a continuation of previously begun programs which are continuing into the present budget period. The Center is currently recruiting a prevention specialist with a nursing and health educational background (M. Etten) who will assume a leadership role in the development of programs of this type in the Center. The program will consist of the following projects:

a. Acquisition of Knowledge Base on Prevention and Health Promotion: The first step in operationalizing this program will be a major literature search and analysis on documented and evaluated prevention and health promotion efforts. It is recognized that a great need exists to discern fact from fad in the area of health promotion and prevention. Dr. Etten and Ms. Newton have principal responsibility for this effort, and this will occur primarily during the first six months of the budget period.

b. Operation of Health Promotion Projects on Exercise, Nutrition, and Stress Control. These three topics have been targeted as meriting early implementation on the basis of current knowledge concerning their impact and effectiveness. These programs will be offered to three types of groups of older individuals in the Tampa Bay area: 1) clients of any of the clinical service projects of the Suncoast Gerontology Center (see continuum of services program); 2) members of specific selected retirement communities including a trailer park, a public housing project, and a high rise retirement project; 3) members of organized voluntary groups such as AARP, NRPA, etc., who request to participate in such programs. Dr. Etten will organize these programs with participation by many of the Center staff members in specific program segments. Dr. Cairl, Research Coordinator, will be

responsible for the evaluation of these programs.

c. Operation HEALTH WATCH: This is a particularly interesting and somewhat complex demonstration and research project which has attracted the interest of the Gulf+Western Foundation, the Tampa Junior League, and the NRTA/AARP Foundation. The actual size of this project (e.g. the number of sites) will be determined by the total resources which will actually become available from each of these organizations. However, core Center resources will be devoted to support the project even if no additional funds are made available.

Operation HEALTH WATCH is a program to be conducted by the Center in some four differing retirement communities in the Tampa Bay area. It seeks to improve the interest and sophistication of health maintaining and health improving activities on the part of entire communities of retirees. It operates in ways somewhat analogous to a neighborhood crime watch program. Selected volunteers from these retirement communities are trained to become "their brother's keeper." The project consists of (1) an intensive three-month series of on-site health education forums, identifying likely health problems and community resources for health and social services related to these problems; (2) the staffing of such sites with a professional health educator/community resource specialist, Nancy Buckley, M.A., O.T.R.; (3) the training of a cadre of neighborhood volunteers to identify emerging health and social problems and to assist members of these retirement communities in appropriate help-seeking for these problems; (4) participation by trained members of the Junior League to serve as assistant health education/community resource specialists; and (5) an impact-of-intervention research program to evaluate the entire project.

This project is expected to commence on July 1, 1982 and to continue formally for 12 months. If it proves to be successful, it will be continued and expanded in other communities.

d. Geriatric Screening and Prevention Clinic. This project is under development by the Clinical Services Coordinator of the Suncoast Gerontology Center, Dr. Patricia Barry, in cooperation with Dr. Barbara Ogur, a member of the Division of General Internal Medicine with a special interest in preventive medicine. The third person involved is Dr. Jeannette Sasmor, a faculty member of the College of Nursing of the University of South Florida Medical Center, who is currently under training to be an adult nurse practitioner. This project is designed to be the initial component of a more general emphasis on early intervention and prevention among the elderly in the community.

The clinic patients will be self-selected and will receive primary care from private physicians, which may or may not include physicians involved with the screening clinic. The clinic itself will operate with a strict protocol which will consist of periodic evaluations at regular intervals as yet to be determined. During these evaluations, screening will be conducted for diseases which are known to be treatable, conveniently and economically diagnosed, and for which a standard screening technique

is available, e.g. hypertension, breast cancer or colon cancer. Patients will be evaluated in this clinic according to strict protocols which will include a history and a physical examination, both of which are directed towards the diagnosis of specific conditions.

Evaluation will include an assessment of functional abilities, mental health, socioeconomic status, and physical health. The service provided in the clinic will also include preventive education concerning steps that the patient may take for his own health benefit, including such things as dietary instruction, breast self-examination, and other similar information. Finally, the Clinic will also provide preventive intervention such as influenza and pneumococcal pneumonia vaccination.

The Clinic will not be responsible for workup of conditions uncovered by such screening techniques; these will be referred to the patient's private physician for further evaluation. The Clinic, likewise, will not be responsible for treatment of ongoing conditions either previously existing or uncovered by screening, for example hypertension or diabetes. These will likewise be referred back to the patient's private physician.

The purpose of such a Clinic is to provide a supplement to regular medical care and to attempt to ascertain the benefits of screening and intervention in the maintenance of health in the elderly community. It is not intended to function in place of regular medical care. Information obtained in the screening clinic will be made available to the patient's primary care physician. Screening should also include the medications that the patient is taking with the view towards the prevention of iatrogenic problems. This information will be communicated to the private physician as well. This clinic is slated to begin operation July 1, 1982.

e. Pre-Retirement Counselling: At the present time the Suncoast Gerontology Center does not offer a separate pre-retirement program but interacts instead with the USF Division of Lifelong Learning in the offering of two broadcast television courses coordinated by Ms. Lee Leavengood. Drs. Tom Rich, Eric Pfeiffer, and Patricia Barry, are participants in these courses on specific topics related to social role, mental health, and health issues in retirement. The first of these courses is entitled "New Perspectives of Pre-Retirement Planning, the second "New Perspectives of Middle Age." Both courses are offered twice a year on Channel 16, WUSF TV. In the past three months we have had three specific requests from businesses in the area to offer pre-retirement counselling to their employees (IBM, J.C. Penny, Tampa Chamber of Commerce), we will be working closely with Ms. Leavengood to develop a program of pre-retirement counselling for these and other similar organizations.

f. Life-Time Learning: The University of South Florida offers to retirees over the age of sixty the opportunity to enroll in any college course free of charge on a space available basis. Presently over 100 persons make use of this opportunity in courses ranging from mathematics to theatre. A recent survey indicates that participation in these courses contributes in a major way to the health and happiness of these older

students. An advisory council consisting of volunteer seniors also provides counselling and technical advice to older students and many times these individuals act in the capacity of personal counselors on matters unrelated to the specific course of study. It is expected that course enrollment by seniors on this basis will increase with the increased emphasis on preventive efforts by the Suncoast Gerontology Center and by word of mouth as well as public advertising of this program in the Tampa Bay area.

5. The Teaching Nursing Home Program

Florida has the highest proportion of elderly (65+) of any state in the U.S. (18% in Florida versus 11% nationally,) and there is every prospect that the proportion will continue to grow during the remainder of this century. This means an already large and constantly growing segment of the population requiring long-term care services is now coupled with a reduction in federal spending on long-term care services, largely through a reduction of Medicaid expenditures by the Federal government. This means that the states in general, and Florida in particular, will have to assume increasing responsibility for the quality and quantity of long-term care services provided within the state.

A powerful new idea to improve the quality of long-term care services in general, and of nursing home services especially, has been developed by such national leadership organizations as the National Institute on Aging on the Federal side, and the Robert Wood Johnson Foundation on the private side. This idea is the teaching nursing home, created by analogy to the teaching hospital which has been so critically responsible in the development of the highest quality of acute and specialty health care services in the United States. Two steps are envisioned in this program:

a. Feasibility Study: The Suncoast Gerontology Center has adopted the concept of the teaching nursing home as a major change agent in the long-term care field and wishes to move forward rapidly towards the operationalization of a teaching nursing home at the University of South Florida Medical Center. Given the fact that a number of practical and conceptual questions need to be answered prior to implementation, a six-month feasibility study will be undertaken.

A number of questions should be answered as part of this study. Each of these questions is to be answered both in terms of the "ideal" teaching nursing home as well as, more realistically, in the context of resources and organizational structures of existing facilities and existing relationships on the USF campus and in the Tampa Bay area.

1. What should be the physical/architectural characteristics of such a teaching nursing home?

2. What should be the organizational relationships and characteristics of a teaching nursing home?

3. What innovative roles can the teaching nursing home assume both in terms of training interdisciplinary personnel working with the disabled elderly and in terms of treatment and rehabilitation as a model of future long-term service provision?

4. What should be the staffing patterns of a teaching nursing home?

5. What type of trainees (doctors, nurses, social workers, occupational and physical therapists, nursing home administrators, nursing home aides, etc.) should be trained in a teaching nursing home?

6. Should the teaching nursing home be developed in existing nursing homes, should it be developed through conversion of existing facilities or portions thereof, such as portions of the Florida Mental Health Institute or another potential suitable facility, or should an entirely new facility be constructed?

7. What mechanism should be developed to translate the findings/products/results of a teaching nursing home for utilization throughout Florida and throughout the region?

8. What would be the financial impact of the development of teaching nursing homes?

b. Implementation of Teaching Nursing Home: Depending on the findings of the feasibility study which will of necessity include resource identification, the Center will move towards operationalization of a teaching nursing home. Depending on the specific recommendations of the study, this may take the form of an application to the NIA, to the Robert Wood Johnson Foundation, conversion of an existing nursing home or other facility in the area, or even building an entirely new facility. Under none of the options listed is it expected that implementation will be complete during this budget period but would extend into subsequent operating years.

It has been decided that Dr. M. Etten would chair the feasibility study task force, under the direction of Dr. Patricia Barry, Clinical Services Coordinator. The State Legislature of Florida has expressed interest in funding the feasibility study, and many professionals in the long-term care field have volunteered to serve on this task force. Even without legislative funding, core Center resources will be utilized to conduct the feasibility study.

6. Dementia Program - "Understanding and Coping With Dementia"

Few human conditions so challenge the ingenuity, courage, resourcefulness and coping ability of scientists, health and social service providers, afflicted individuals and their families as does progressive dementia. This is a brain disorder which causes major memory loss and generalized intellectual deterioration while leaving other aspects of personality generally intact, at least in the early and mid stages of the disease. The disease is slowly progressive and may extend over a period ranging from two to as many as fifteen or twenty years. The disease affects from five to ten percent of individuals over the age of 65 and accounts for nearly half the persons admitted to or residing in nursing homes. The human and the fiscal tragedy associated with this disorder galvanizes our attention and persuades us to make major investments in understanding and coping with this disease. The Center's Dementia Program consists of the following projects:

a. Study of the Effect of New Drugs on Symptoms Associated with Dementia: The Center Director is principal investigator of an eight-site double-blind control study of a new drug, Praxilene, versus placebo on symptoms associated with dementia of the Alzheimer's type. The study is interdisciplinary in nature and includes psychiatric, psychological, neurological, and social evaluation of patient behavior. The drug appears to have promise of causing some improvement in memory performance and even more marked improvement in initiative, sociability, and self-care capacity. This project is now just beyond the halfway mark. It has resulted in large amounts of data on physiological and psychological performance by patients with Alzheimer's disease as well as in epidemiological data concerning it. Interestingly, the drug study has also been the starting point for a number of related projects (see below). The Center is currently also conducting an open study of the same drug to determine its long-term efficacy and safety. Both of these studies are fully supported by the drug manufacturer.

b. Alzheimer's Family Support Group: As part of an overall focus by the Center on the care of the care-givers, and growing directly out of our experience with Alzheimer's disease patients in the drug study, the Center began the operation of an Alzheimer's Disease Family Support Group in June of 1981, under the leadership of Lillian Middleton, M.S.W. This group has grown rapidly from some ten initial members to in excess of fifty members from all over the Tampa Bay area. The group constitutes a genuine partnership between professional staff (social work, psychiatric, medical, and legal) and peer group leadership in which members learn from each other as well as from professionals. The focus is on sharing of coping techniques for the various stages of the disease. This support group has aided many families in allowing them to keep their relatives at home rather than admitting them to a long-term care facility at great personal and financial expense. It has also prevented family disruption and abandonment of care-giver role. The burgeoning growth of the group will shortly give rise to the next project in the Dementia Program of the Center (see below).

c. A network of Alzheimer's Family Support Groups in the Tampa Bay area: Given the fact that there are large numbers of patients with Alzheimer's disease in the Tampa Bay area with its over one-half million elderly over age 65, and given the fact that participants now come to the Suncoast Gerontology Center from as far away as two hours driving distance, the Center will shortly undertake the development of a network of satellite family support groups. The Center will continue to support these satellite activities through staff support and leadership training as well as through the provision of professional expertise and assistance. Additional outside funding is being sought from the Gulf+Western Foundation for the expansion of this program. The program has also attracted some significant private donations and contributions. The beginning of the network of family support groups is slated for July of 1982.

d. Production of Three Professionally Produced Films on Alzheimer's Disease: Center staff are currently engaged in the production of three professionally produced films aimed at health and social service providers and at lay audiences on the topic of "Understanding and Coping with Dementia." The film series has three parts: 1) recognition, 2) management, 3) course and outcome. The film contains direct patient and family observations, didactic content on diagnosis, management, community resouces and coping techniques. Review of the first of these films indicates that it is of outstanding scientific as well as artistic quality. Attempts will be made to show this film series on public television. Production of these films is underwritten by the educational division of a private pharmaceutical company. The participation of members of the Alzheimer's Family Support Group has been very heartening to Center staff.

e. Alzheimer's Disease Brain Bank: Efforts are currently underway to establish an Alzheimer's Disease Brain Bank, in connection with the Department of Pathology at USF. This brain bank will form the initial entry in a major effort to mount substantial biomedical studies into the causes of Alzheimer's disease and related types of dementia. Funding for these efforts will not be supported by AOA funds but instead will be sought from the National Institute on Aging (NIA), the Veterans Administration, and from private contributions.

7. Resource Development Program

While AOA monies provide core funding for staff and program activities, it is clear that these resources are not sufficient to operate the broad range of programs outlined in this grant. The Center is committed to seek funds from other federal grant programs, from the Florida State Legislature, from foundations and private donors, as well as to generate program income from private or third party payors. A very successful resource development workshop during the past year has helped in identifying resources and action steps and will become a permanent part of this

resource development program. Specific responsibility for Center resource development will rest with the Center Director, the Assistant to the Director, and the Research Coordinator. These individuals will be assisted in this task by all other staff members on an ad hoc basis. They will also be supported by the University's Office of Development and the Medical Center's Development Officer who are already actively working with the Center on resource development. Specifically, the resource development program will include the following steps:

a. Seek other federal funds: Individually or by joint research with other operational centers, we will respond to those RFP's issued by federal agencies which will enhance and/or expand other activities carried out within the Center. Such plans include NIA (see also Teaching Nursing Home) and NIMH on the national and the VA Hospital on the local level. The latter have already committed an array of resources to include facilities, staff and research support.

b. Explore Community and State Resources: The Center will continue and accelerate efforts toward joint activities with State Program Offices, Areawide Agencies on Aging, and community service providers with an eye towards developing more resources for program development and program refinement. The proposal to the state legislature with regard to the the teaching nursing home (see section 5) is but an example of the Center's attempt to gain resources within the state's political structure.

c. Generate Income from Third Party Payors: Through clinical services such as the Assessment Program and other pilot projects, the Center anticipates generation of income from third party payors or private payors.

d. Apply for Funds from Private Foundations: The Center has and will continue to seek foundation funds to support programs and personnel. Proposals have been submitted and personal contacts have been made with the Robert Wood Johnson Foundation, the Gulf+Western Foundation, the Conn Memorial Foundation and NRTA and AARP of the Andrus Gerontology Foundation.

e. Seek Corporate Giving: The Center plans to take advantage of the increasing dollars made available nationally through corporate giving. Insurance corporations as well as many corporations who take advantage of the retirement industry in this area are probable targets. Corporations such as Internal Minerals Company (IMC) in Tampa, offer to match contributions from their employees at different ratios if the contribution is made to an institution or organization. Such a gift has been received and others like it will be sought.

f. Intensify Joint Projects with the University Development Office and Specifically the Director of Development within the USF Medical Center. Both offices are currently helping to pave the road for individual giving programs which will benefit the Suncoast Gerontology Center. Prospective donors exist who have expressed an interest

to support the Center through wills, bequests, etc.. Over $7,000.00 in contributions have been received during the first operational year, and all indications point to ever increasing contributions in this area of fund raising.

g. Increase Publicity About the Opportunity to Become A Member Of the Suncoast Gerontology Center: For a $10.00 contribution, individuals, organizations, or foundations can join the Center as members who receive information about Center programs and activities and are invited to attend an annual membership meeting featuring experts in the field of gerontology and geriatric medicine. Presently the Center has forty members.

h. Encourage Affiliates and Private Individuals Interested In Center Activity to Become "Volunteer Fund Raisers" and also recruit them to volunteer their time and expertise in planning and implementing Center programs. Physicians and social service professionals at all ages and backgrounds have offered their assistance, and the strong commitment of Tampa Junior League to the Center (as described in section 4) illustrates that a successful future volunteer program is underway.

8. Interdisciplinary Training Program

The multidimensional problems of the elderly mandate a multidimensional approach to service. However, the Center is not content with simply training professionals from a variety of disciplines but insists on training them together. This is based on the assumption that they are more likely to work together successfully in community settings if they have trained together. We also feel this leads to a correct appreciation of each of the several disciplines by the others and to a great deal of learning from each other during the training period. The interdisciplinary training program at the Center has the following components:

a. Interdisciplinary Training Of Doctors, Nurses, and Social Workers:. These principal disciplines each receive joint training under the general supervision of the Education and Training Coordinator, with participation of all the clinical disciplines involved in the Center. Training sites include:

- the Suncoast Gerontology Center with all staff, library and consultant resources engaged in carrying out the ten proposed programs outlined in this grant.
- other University programs and departments interacting closely with the Suncoast Gerontology Center, such as the Department of Gerontology, Division of Lifelong Learning, and the University Medical Center Ambulatory Care Clinic.
- two VA hospitals, Tampa General Hospital, and several LTC facilities in the immediate vicinity of the Center.

- at least ten community-based human service organizations offering comprehensive health and social services.

The experience provided through these sites also will assure extensive exposure on the part of the trainees to both well and disabled elderly and their families.

Students from each discipline will have two faculty advisors, one from his/her "home department" who will assure that the disciplinary in-depth training is well covered and well coordinated with the inter-disciplinary training received through the Suncoast Gerontology Center. A faculty member from the Center will also work closely with each trainee.

b. Continuing Education of Professionals Already Working With the Elderly: The Center has an active program of conferences and seminars providing one to three day training sessions, seminars and workshops for physicians, nurses, social workers, long-term care administrators and other health and social service providers in the region on a broad range of topics related to the elderly. This program utilizes Center, University, community, and outside consultant resources. Conferences proposed for this funding period are:

- Health Care of the Elderly: A Challenge to Medicine. An annual conference geared to physicians and health professionals, offering a broad range of social/psychological and medical issues on aging.
- Community Conference on Initiatives in the Continuum of Care: An annual conference geared to all human service professionals who need training in applied areas of health and aging.
- Resource Development Workshop: To continue our successful endeavor of brainstorming additional resources and strategies to tap these resources.
- Understanding and Coping with Dementia: Geared to families of afflicted persons as well as health and social service professionals.
- Long-Term Care: Workshop for staff (including hands-on personnel) within a long-term care facility to teach them psychosocial support concepts.
- Two training workshops on Assessment Methodology for professionals in the field who need a better understanding of all aspects involving functional assessment and evaluation of assessment instruments.
- Elderly in Distress: A conference for police and other authorities who encounter elderly persons in times of trouble. It will provide knowledge of special physical and mental health conditions (confusion vs. intoxication, hyperthermia, behavior as a result of being a crime victim, etc.)

c. Educational Products Generation: It is the Education and Training Coordinator's responsibility to stimulate and coordinate the production of curriculum syllabi, teaching films, video cassettes and tapes and other course products. As an example, the Center will videotape the Public Forum series described in Section 3 and schedule showings of these tapes at various community locations and centers frequented by the elderly. The videotapes will be accompanied by a specialist who can answer questions related to the topic discussed on the tape. A handbook, ISSUES IN AGING, capturing the forum presentations and organization, will be an additional product for distribution. Other examples of educational products are: A series of films on dementia as described in Section 6, a training manual for LTC providers, and training and instruction manuals on assessment instruments. In addition to using them with community groups, these products can also be disseminated to other training facilities and they can be utilized in technical assistance programs described in Section 2.

d. Training of Hands-On Personnel: The Center has just begun negotiations with the Florida Health Care Association, an organization of nursing home administrators, to provide training for nurse and nurse aide staff in the care of elderly patients. A two-day workshop for administrators and other key staff of LTC facilities will be held to provide them with in-service training models for psychosocial support concepts and strategies. They will learn to identify or create resources in their facilities which will improve real care-giving, involving housekeeping and maintenance staff. A training manual developed by the Education and Training Coordinator will be distributed to workshop participants and will also be used as one component of a comprehensive approach to the Teaching Nursing Home training program.

e. Center Staff Interdisciplinary Training: Twice a month the professional staff at the Center and faculty from affiliated departments and invited community representatives will convene for a Service Systems Policy Development Seminar (outlined in Section 1b.) These discussions on service development topics are expected to yield concrete policy suggestions, but beyond that, this interdisciplinary exchange of ideas will enhance the atmosphere of colleagual problem solving and solidify the basis of mutual support and coodination.

Individual members of the staff of the Center are also continuing their own in-depth education in geriatrics and gerontology through clinical experiences in geriatrics programs overseas for days or weeks at a time, returning to the Center with improved knowledge and teaching skills. Funds from the National Institute on Aging, resources of the various departments of the University, and other outside funding sources rather than AOA funds are being utilized for these purposes.

9. Continuum of Services Program

It is clear from clinical experience that older individuals do not go from a state of complete wellness to severe disability in one step but instead experience many changes and exacerbations as well as improvements, each of which may require differing types and differing intensities of services. The system of services still suffers from having too few entries between "no care" and "complete care," resulting in "too much" or "too little" care. The continuum of services program is designed to remedy this situation by developing model services along this continuum. During the next budget period the Center intends to operate the following model service programs, either directly, or through its affiliate organizations:

a. Comprehensive Geriatric Assessment Unit: The Center will continue to operate its Comprehensive Geriatric Assessment Unit with participation from all clinically trained Center staff. A great deal has already been learned from this unit during the present budget period. In particular, staff and patient alike have learned the heartache of "all assessed and no place to go."

While documenting the value of comprehensive assessment and of care planning, the unit has also highlighted that many needed services are not available in the community or are not available in sufficient quantity. The Center will use its efforts during the next period to stimulate needed but unavailable service in the community or in its affilate organizations.

b. "Care of the Care-Givers": Another finding from the Comprehensive Assessment Unit has been the identification of an important new function of a clinical services program, the care of the care-givers. This need arises particularly when the identifed patient is actually not capable of further treatment or rehabilitation. Services to the care-giver, however, can allow the care-giver to function in his role, thereby avoiding institutionalization for the affected individual. Care of the care-giver highlights a whole array of complex issues which need to be addressed. The service system is unprepared to deal with care provided to individuals other than the "identified patient." This causes difficulties in assessment with medical records, and with reimbursement mechanisms. "Patient" may be a patient with advanced cancer or with advanced dementia, but the service worker spends all of his/her time with a spouse who has no "standing" in the medical record, the case file, or the Medicare system. Given that the Center has identifed the care of the care-giver as an absolutely vital activity, it intends to develop recommendations for changes in the system to "accommodate" these new types of clients who are, at once, service recipients and service providers.

c. Grief Support Group: The Center has just begun the operation of a grief support group for individuals who have recently been bereaved,

under the direction of Nancy Buckley, Rehabilitation Counselor and Dr. Guillermo Dardano, Geriatric Psychiatrist. The Research and Evaluation Coordinator will study the impact of this group on participants.

d. Joint Programs With the Florida Mental Health Institute: As the Florida Mental Health Institute has only recently come under the jurisdiction of the University of South Florida, the Center will be working closely with FMHI staff to develop and operate joint program activities between the two organizations. FMHI projects currently include a skills-training oriented day treatment program and a rehabilitation oriented residential treatment program. Center staff currently provide intensive case management services to selected day treatment patients and psychiatric services to participants in the residential geriatric program at FMHI. A planning process to identify other joint programs has been set in motion but will require several more months to be fully implemented.

e. Joint Projects with the Tampa VA Hospital: Center professional staff in both medicine and psychiatry continue to provide leadership in the operation of a specialty geriatric psychiatry and a specialty geriatric medicine unit at the Tampa VA Hospital. Each of these programs provides not only specialized acute care with reciprocal consultation between the two programs, but also serves as a training ground for residents and fellows in medicine and psychiatry as well as for a variety of other health and social service provider personnel. The two programs are also the sites of several research projects which are jointly operated between VA staff and Center staff.

10. Pre-Nursing Home Assessment and Assessment Methodologies Program

To determine whether a community service system meets the diverse needs of the elderly is in part dependent upon the availability and use of comprehensive and reliable multidimensional assessment instruments in the system. In the absence of such instruments, there is an increased probability of a relatively large proportion of elderly being inappropriately channeled into service and service settings which do not match their needs. This carries with it not only unnecessary human costs, but also unnecessary and indeed inflationary economic costs as well.

Recognizing this fact, the Suncoast Gerontology Center has and will continue to place emphasis upon the development and evaluation of comprehensive assessment tools which can be effectively used across the spectrum of service interventions ranging from health promotion and prevention services to long-term care services. The program consists of the following projects:

a. Pre-Nursing Home Screening Project: The purpose of this project is to develop, implement and evaluate a pre-nursing home assessment procedure which has the potential of reducing the proportion of elderly persons inappropriately placed in nursing homes and to concomitantly insure a more efficient use of long-term care dollars. In developing this procedure, emphasis will be placed upon the applied implications of enhancing the practicing physicians' (and other health professional's) placement decision-making process through the use of an inexpensive multi-dimensional screening battery and related decision rules or guidelines which replicate multidisciplinary clinical team judgements. A relatively complex research design will be used to evaluate the resulting procedure and to identify points in need of modification or refinement. Additional funding for this project has been requested from the Robert Wood Johnson Foundation.

b. Functional Assessment Inventory (FAI) Evaluation Project: Since the inception of the Center, The Functional Assessment Inventory has been used as a primary assessment tool for clinical services case management as well as research. This instrument, which represents a distilled version of the OARS battery developed at Duke University, was designed by the Center Director, Dr. Eric Pfeiffer. Although some methodological sub-studies on the reliability and validity of the instrument have been performed, the proposed project would serve to continue this direction of evaluation. Of particular importance in this regard would be a study designed to compare the predictive validity and reliability of the FAI with the overall OARS battery.

The proposed project would, in addition to performing evaluation research studies, involve the development of training and instructional manuals on the FAI. These manuals would be diffused throughout the service system.

c. Development of an Environmental Assessment Inventory (EAI):

During the initial operational grant year, Center staff developed a draft Environmental Assessment Inventory (EAI). This instrument is designed to assess various dimensions of the person/environment complex as they relate to health, mental health, and functional status.

The proposed project will involve further development and evaluation of this instrument. The evaluation studies will focus upon problems associated with the administration of the instrument as well as validity and reliability checks. Once this instrument has been refined, training and instruction manuals will be developed for diffusion in the service system.

d. Geropsychology Assessment Laboratory: This project represents a joint venture between the Suncoast Gerontology Center, the Department of Gerontology and the Clinical/Community Division of the Department of Psychology, to develop a laboratory of Gerontological Psychology for training, research and clinical services. The specific objectives of the project will be to 1) develop a program for the evaluation of psychological assessment/clinical

instruments for use with older clients, families and significant others, 2) develop a resource file on major assessment instruments with supportive empirical research on reliability and validity, 3) train students on multi-disciplinary assessment and on the appropriate utilization of psychological evaluations and, 4) develop an ongoing program of research on clinical prediction measurement scale development and reliability and validity testing.

e. Sensory Loss Evaluation Project: The objective of this project will be to develop, in concert with the Department of Communicology, a program of training and research on sensory losses, especially hearing loss, in the elderly. This program will provide a context for the training of health and allied health personnel regarding the effects of sensory loss or deprivation on various medical, social, psychological and behavioral patterns. In addition, the program will foster basic and applied research on such issues as early intervention and detection techniques, treatment modalities, and rehabilitation programs relative to sensory losses in the elderly.

Senator HAWKINS. Your first recommendation is that you would like to mandate——

Dr. PFEIFFER. Preadmission assessment by someone other than the admitting facility.

Senator HAWKINS. Who would that be?

Dr. PFEIFFER. I think that is part of the system to be developed, but it can be a community agency not directly affiliated. It could be done by standards set that could be within that system. The danger of certifying through your own facility that you are in need of this kind of service is an obvious potential conflict of interest. I realize when a potential conflict of interest exists, people do not necessarily act on the conflict of interest, but that potential exists.

Senator HAWKINS. I understand that the Suncoast Gerontology Center in Tampa is one of nine such centers nationwide.

Dr. PFEIFFER. Yes.

Senator HAWKINS. And the only one we have in the Southeast.

Dr. PFEIFFER. This is the only one in region IV of the HHF region that is based in Atlanta. One of our responsibilities is to provide technical assistance and advice to State agencies throughout the Southeast.

Senator HAWKINS. You had a lot of statistics, which I appreciate, in your report.

Dr. PFEIFFER. They are in the report.

Senator HAWKINS. Are we still far from having enough physicians trained in the geriatric field?

Dr. PFEIFFER. Yes, I think we are still far enough away because persons like myself who finished medical school in 1960 never had any training at all in geriatrics or gerontology. I am somewhat considered an expert in this area, and I am a person without training. Now we are able to include this training in medical schools. I think the effort of the long-care term gerontology centers of the Administration on Aging and the second effort by the National Institute on Aging to create geriatric academic medicine awards has produced efforts in approximately 75 percent of all the medical schools in the United States to have some specified efforts in the training of geriatrics for the next crop of doctors.

What we do not have yet is any major formal mechanism for the continued training of physicians who are already in practice and

who were trained like myself without the opportunity for gerontology/geriatrics.

The Wall Street Journal of Friday, March 19, on its left-hand column, has an excellent article on medical advances, medical schools beginning to stress the need for specialists in treating the elderly. It is a well-documented article on how widespread this is, but also how recent the interest is. I would like to recommend this article.

Senator HAWKINS. We will put that in the record also, if you do not mind.

[The article referred to follows:]

VOL. CXCIX NO. 54 ★★
WALL ST. JOURNAL
Medical Advances

Schools Begin to Stress Need for Specialists In Treating the Elderly

Geriatricians Are Very Rare In a System That Neglects Unique Ills of the Aged

Is It Senility or Just Sadness?

By Michael Waldholz
Staff Reporter of The Wall Street Journal

Walter N. Roman was robust until he reached the age of 85. Then, suddenly, he began to act senile. He was confused, lost his memory and became hostile. His doctor, who had been treating him for a mild heart condition, suggested that he enter a nursing home.

"I was imagining things," Mr. Roman now recalls, nearly two years after his brush with dementia. "My grandchildren tell me I said things I don't remember saying."

In their desperation, Mr. Roman's family sent him to a geriatric clinic at New York's Bellevue Hospital. It is one of the handful of such programs that exist in the U.S. There, Dr. Michael L. Freedman found in Mr. Roman a problem sometimes encountered in elderly heart patients. The heart medicine he was taking wasn't being excreted properly by his kidneys; the high levels of the drug in his body caused a condition mimicking senility. Once taken off the medicine, Mr. Roman returned to normal.

Inattentive to the Elderly

The treatment Dr. Freedman administered didn't involve a miracle cure, though as far as Mr. Roman and his family are concerned, the recovery was indeed miraculous. And few doctors in America are trained to detect what Dr. Freedman did. Gerontologists, the physicians and other professionals who specialize in the study of old people, say that scandalously little attention is paid to the special problems of the aged. And that is true even though patients over 65 account for one fourth of hospital stays and for 30% of the nation's $220-billion-a-year health bill.

Gerontologists blame the inattention on ignorance and prejudice. "Most doctors just aren't trained to understand the normal process of aging," says Dr. Robert L. Kane, a professor of medicine at the University of California at Los Angeles Medical School. "Normal is often treated like disease," he says, "and disease is often ignored."

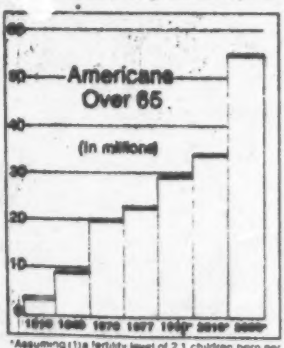
Thus, it isn't unusual for the medical problems of the elderly to be incorrectly diagnosed, inadequately treated or completely missed. Drugs alone and in combination, can create problems such as Mr. Roman experienced, particularly in patients who are being treated for several diseases concurrently. Until recently, there had been scant research on many illnesses common among old people, including dementia and incontinence.

A Lack of Specialists

Gerontologists say that untold millions of dollars are spent on inappropriate care. And patients and their families are enduring unnecessary physical discomfort and anguish. At least some of the 1.3 million Americans in nursing homes would not be there if they had access to specialized treatment.

Until a few years ago, there were few special programs to treat the elderly outside of nursing homes, nor were there many specialists in geriatric medicine. Five years ago only a few medical schools offered so much as one course in geriatrics. More than half of them do now, but there still are fewer than 5[illegible] geriatricians in the country and only six fellowship programs to train more specialists.

"There's an enormous need for more doctors schooled in geriatrics, says Dr.



*Assuming (1) a fertility level of 2.1 children born per woman and (2) that mortality rates decrease at a rate whereby life expectancy at birth increases by about 05 year per year
Source: Census Bureau

Robert N. Butler, who heads the National Institute of Aging and who, in September, will take over the new department of geriatrics at the Mount Sinai School of Medicine in New York. Dr. Butler says that he hears regularly from people with elderly family members. They "like their own doctors," he says, "but feel a need now for something more."

Hospitals, too, have become concerned about burgeoning populations of elderly patients who are well enough to be discharged but too fragile to go home. When patients can't find, or can't afford, skilled nursing facilities, they stay on longer in hospitals.

There is just such a shortage of nursing homes in Rochester, N.Y., where on any given day roughly 246 hospital beds are occupied by aged patients with no place else to go. To break the logjam, Rochester's six hospitals have set up the nation's first city-wide geriatric assessment program. A doctor, a nurse and a social worker cooperate to speed the recovery of patients, improve

Please Turn to Page 14, Column 2

Medical Advances: Specialists Who Treat the Elderly Are More Numerous in Hospitals and Nursing Homes

Continued From First Page

their functioning and get them out of Rochester's hospitals.

But few hospitals employ such expert talent. Mount Sinai Medical Center in Chicago, for instance, for seven months has been trying to hire a geriatrician. Dr. Maurice A. Schwartz, the hospital's chairman of medicine, says that "that's an unusually long time" to be looking fruitlessly for a doctor to fill a position.

The medical profession has been slow to respond to the need for geriatricians, and the need is growing. The population over 65 is expected to reach 30 million by 1980, up from 26 million today. A 1969 Rand Corp. study noted that although 10% of the population already is over 65, a poll of practicing physicians found that only 0.2% of doctors regarded care of the aged as an important part of their practice.

Much of the felt need for geriatrics training has come from two government actions. In 1976, Congress created the National Institute of Aging, which has promoted the first research programs within nursing homes and has backed university education and research in geriatrics. In 1978, the National Academy of Science's Institute of Medicine, in a study financed by the government, urged the courses in geriatrics be included in every medical-school curriculum. The recommendation has brought about fast growth in such programs.

Despite an increase in interest, people in the field believe that the needs of the elderly won't be served until a new generation of medical students has been educated differently about treating the aged. "I tell my medical students if they want to do something easy, stay out of geriatrics," says Dr. Richard Besdine, a practicing geriatrician and professor of medicine at Harvard Medical School. Caring for the old, he says, requires patience and an acceptance that success with a patient usually means improvement rather than cure.

Students traditionally have been infected early in their training with the idea that treating the chronically sick elderly patient is a no-win undertaking. Dr. Neil Resnick, a young physician who trained under Dr. Besdine, says that first-year students may see old people as "sweet and venerable, like their grandparents," but after four years of indoctrination "they *know* that old patients are the worst. They think of them as hypochondriacal, foolish, demented, incontinent, nonresponsive, all-around pains in the neck. 'Who needs this?' they think."

Negative attitudes are reinforced by the sorts of contact medical students have with elderly patients. Dr. Resnick adds: "Students see patients when they are the sickest, when their reserves are depleted. They often are angry or scared, and they are hostile. Students rarely see what can be done for them or experience the satisfaction of trying."

Dr. Resnick is a graduate of one of only six geriatric fellowship programs in the U.S., each of which is designed to produce teachers of geriatrics. The first of these programs, the one at the Jewish Institute of Geriatric Care on Long Island in New York, began six years ago. The 527-bed facility appears to be a nursing home, but it can boast of accomplishments few nursing homes can match: About one-fourth of its patients eventually are sent home. The program emphasizes rehabilitation of stroke victims, amputees and other debilitated patients.

The Long Island facility is unusual. Nursing homes seldom employ full-time doctors, particularly physicians with specialized training in geriatrics. The institute's founder and medical director, Leslie S. Libow, patterned the facility after teaching hospitals, the best of which "attract the brightest doctors, encourage research and provide facilities to teach medical students and young doctors," Dr. Libow says. "I thought, Why can't we do the same in a nursing home?"

Back to Normal

The institute stresses rehabilitation, getting older patients for whom improvement is possible back to a normal existence. "In geriatrics," Dr. Libow says, "the general rule is that improvement of functioning is everything." Thus, it is not unusual to see even double leg-amputees in their 70s and 80s being encouraged to walk again.

Moritz Nudel, whose broad shoulders and firm handshake make him seem younger than 80, goes each day to the institute's outpatient center, preparing to walk on artificial limbs. He lost one leg several years ago to a circulatory disorder; his remaining leg was removed recently. Asked whether he had considered the possibility of not being able to walk, Mr. Nudel says, "No, my wife wants a whole man."

Geriatric care requires more than medicine, involving as it does some attention to the patient's psychic needs and living conditions. And that is why NIA's Dr. Butler believes that "doctors have to come off their high horse and be willing to work within a team of health and social workers. For a geriatrician, these people can be his most important tool." Medical treatment of the aged differs, too.

Diseases manifest themselves differently in older patients, and treatments differ. For example, researchers now know that drug dosages standardized in studies of younger patients often aren't right for old people, particularly for patients who are taking a variety of drugs that interact. And diseases often are misdiagnosed, particularly as senility.

Senile or Just Depressed?

Dr. Jack Rowe, a professor at Harvard Medical School, says that many older patients are thought to be senile, or demented, when in fact they merely are depressed. "While a younger person might say he feels down, an older person who is depressed will act withdrawn, confused, and he'll lose intellectual abilities," Dr. Rowe says. "If correctly diagnosed, this depression can be treated. Instead of being put away in a nursing home, he can be rescued."

Some diseases that commonly affect the old still are largely ignored by medical science. Dr. Rowe says that that is true of incontinence, the loss of bowel and bladder control. The problem, he says, may account for 25% of nurses' time in homes and hospitals. "Yet, until recently, all research concerned itself with incontinence in bed-wetting children or middle-aged women," he says. If incontinence were better understood and better treated, many people in nursing homes wouldn't be there. "A family can deal with almost anything but incontinence," says Dr. Rowe. It often is the last straw, he says.

Doctors who treat the aged say that one rule for the geriatrician is to intervene where medical care is doing as much harm as good. Dr. Frederick Sherman, a geriatrician at New York's Mount Sinai hospital, tells of a recent patient admitted to the hospital unable to walk because of gangrene in two toes. The man, 87, blind, diabetic and deaf, was, nonetheless, independent until he was hospitalized.

Once institutionalized, the man became despondent. He had trouble urinating because he was bedridden. He got bedsores and became constipated. As a result of his discomfort, he became uncooperative. To calm him down, he was given tranquilizers that made him sleepy and obstinate.

Dr. Sherman examined the patient and was able, he says, to improve the man's hearing right away simply by cleaning his ears of impacted wax. He sent home for the man's hearing aid. The next step is to get him walking again.

"The patient, in the condition he's in, is a prime candidate for a nursing home," says Dr. Sherman. The geriatrician's challenge is to get him on his feet and back home instead.

Senator HAWKINS. I know as an amateur nutritionist, which I took up just as a hobby at about the time you graduated from medical school, I was appalled at how little nutrition doctors studied. We have a lot of close friends and they became outraged when they found how little training physicians had in nutrition. I could show you samples of letters that physicians have written to medical schools saying, "Why didn't you teach me something about nutrition or health? We always study disease and the curing of disease and drugs and that type thing." That was back in the sixties.

Now we are in the eighties and we see that medicine has lengthened our lives and because of that we are in need to know more about nutrition in order to stay healthy those extra number of years that we are going to live.

That is why panels like this are so important. Every piece of information that we can glean and put together in a report is new material because this is a new problem that none of us really expected, although I have never met anybody that is planning not to live. They tell me that we are a country that idolizes youth and yet we are a country that is growing older. The alternative to not growing older, I do not want to face myself.

Dr. PFEIFFER. We have a model at the Suncoast Gerontology Center that says that the sun setting is not less beautiful than the sun rising.

Senator HAWKINS. As director of the center, would you explain what the center does?

Dr. PFEIFFER. The center is a university-based center, but it is community-oriented.

Senator HAWKINS. It is university based?

Dr. PFEIFFER. We are located in the university, but our focus really is the surrounding region of universities, the State and really the region of the eight States that we operate in. We are a composite organization that includes several departments of the medical school, including family medicine, internal medicine, psychiatry, and neurology, the college of nursing, the department of social work and the department of gerontology as major components. Then we relate to outside agencies in the community.

Senator HAWKINS. Are you finding that geriatrics is attractive to the young medical students and nurses?

Dr. PFEIFFER. To more and more young medical students and nurses it is becoming attractive at the moment. We have been able to recruit some young faculty members who I think are excellent exponents of what it takes to be a good physician to an older person, which begins (a), with liking older people and (b), with being able to communicate with the older person and (c), having specific knowledge in the aspects of health care that are totally different in regards to the elderly from those of the young.

We have had pediatrics for a long time and people do not ordinarily take their children to just a regular physician. They still take them to pediatricians, although family medicine, I think, is developing some expertise in this area as well. A geriatrician is almost nowhere to be found, even in an area of the country where roughly 25 percent of the population is over 65 years of age.

So, the development of individuals on the faculty level who can serve as models of what kind of physician to become, I think, is one of our goals.

Senator HAWKINS. How do you make sure that your ideas are disseminated at the community level?

Dr. PFEIFFER. We do a great deal of publicizing. We have in our report a number of materials. We publish a newsletter which goes to all interested parties, called Aging Information.

Senator HAWKINS. Who would an interested party be?

Dr. PFEIFFER. Professionals working with the elderly and family members who are interested in the well-being of their elderly family members.

We tried to do a cross-cutting job of professionals. By that we mean physicians, nursing home administrators, nurses, social workers and so on, as well as interested family members whose relative may be in need of ongoing care.

We also do a great deal of continuing medical education. I brought with me some of the conferences held for physicians and other professionals on the health care of the elderly, subtitled "A Challenge to Medicine." I think it used to be thought that the medical care of the elderly was something for somebody to do who couldn't do anything else. I think we feel the very opposite today.

The most challenging issues exist in dealing with the elderly people who have multiple problems in multiple areas of their functions, including the long-term care system. I think we as physicians need to become far more drastically involved in long-term care. For this reason we have approached a number of new avenues.

For instance, development of a teaching nursing home to mainstream long-term care. We have been sending bright young doctors and nurses to our teaching hospitals. They have improved the quality of care in those facilities, but the trainees are only rarely exposed and even still more rarely participate in long-term care.

We would like to change that, not only locally, but as a national policy.

Senator HAWKINS. Do you have any programs that invite the participation of the community to work with your physicians and with the nurses, et cetera, that are going to be working in nursing homes?

All of the testimony I have heard stated the great need for the community to assume their responsibility in visiting and making families out of these people that are homebound.

Dr. PFEIFFER. Yes, we have a number of programs that teach elderly persons what is available in the community and how to make their voices heard.

Senator HAWKINS. Do you have any courses or are you anticipating as one of your goals, a course that would teach volunteers how to work with the elderly.

Dr. PFEIFFER. In our planning, yes. We have only been in operation about a year and a half now, and I think we have accomplished a good deal, but we have been, I think, smart enough not to take on everything at one time. Volunteer programs are in our plans, but currently we have not yet actively been working with the teaching of volunteers, but have been working with relation-

ships with the junior league and a number of other community organizations who wish to be involved. These are being developed.

Senator HAWKINS. Do you have a published list of goals?

Dr. PFEIFFER. We have a published list of 10 major undertakings that we feel we need to address over the next 10 years. I would like to share a few of those with you.

The first of these, really, is to reexamine the entire system of long-term care as a system on the national level, not just simply in a local geography.

The second goal is interdisciplinary, that is the simultaneous teaching of a variety of professionals working with the elderly to give them professional skills and the specific skills of working with the aged, and to work together. We have for too long gone down a pathway that there was a medical care system and a social care system. The elderly person does not know the difference. He hurts and he needs help most of the time. We feel by training people together, we can improve the likelihood they will work successfully together.

A third area of our major undertaking, I think, is in the area of some specific diseases, which particularly impinge on the long-term care residents, namely, memory disorders, Alzheimer's disease, and post stroke, multi-infarct dementia. We know that approximately 50 to 55 percent of all persons residing in nursing homes suffer from major memory deficits. We have a major program of studying and facilitating the care of persons with memory disorders.

A fourth major area is in the area of prevention and health promotion of the many people who come to Florida perfectly well when they initially come here. They are interested not in care but in staying the way they are. I think this means educating them to what they might expect, educating them as to what they can do to participate in their own maintenance of good health. That includes nutrition, exercise, and recognition of early symptomatology and so on.

We also have a program of assessment methodology which I mentioned already concerned with developing prenursing home assessment for all nursing home populations. Beyond that, we are concerned that while assessment is an important issue we currently are in a system that has good acute medical care and improving nursing home-based long-term care, but very little in between.

We have had a saying that we find many of our patients can be adequately evaluated and assessed and then they are all assessed with no place to go. The service intermediate to complete care or complete independence is largely not yet available in the community. I think these need to be flushed out as steps. By having these steps available, I think we will decrease the fiscal expenditure and the human expenditure at the nursing home level.

I think the rest of the material can be obtained in the documents.

Senator HAWKINS. Thank you so much, Dr. Pfeiffer.

We commend you in the endeavors of the center and wish you great success. I can't help but make an observation that to a lot of the volunteer organizations who have long been interested in this, your center would be a great source of information and help.

Dr. PFEIFFER. We are delighted that the Senator from Florida placed this issue on the agenda, and are hopeful that this will be a continuing issue in the future for the committee.

Senator HAWKINS. You are so right. I cannot tell you the number of Senators, for instance, that stop me and say, "I just purchased a little condominium in Florida. I want to get my real estate down there early, but I am still actively working and I sneak down there——"

Dr. PFEIFFER. Would you send me their names?

Senator HAWKINS. They plan on being as they are now when they get to that residence. It is just a little hideaway now, but that is where they are going to retire when they stop working.

Our population is going to continue to increase. People are growing old gracefully and have no concept of ever being ill. It is a problem and concerns me every time I am stopped, and that is on a daily basis.

We will now turn to Mrs. Pam Parker, who is a representative of the National Citizens' Coalition for Nursing Home Reform. This coalition has worked long and hard to raise a united consumer voice on the regulations that we came here to discuss today.

STATEMENT OF PAMELA J. PARKER, NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM, WASHINGTON, D.C.

Ms. PARKER. Thank you.

We want to thank you for the invitation to testify here today. I do represent the National Citizens' Coalition for Nursing Home Reform.

Since 1977, I have served on its executive committee as secretary of the board. We represent over 110 citizen organizations and agencies in 32 different States who are actively involved in efforts to improve the quality of care and life of persons residing in nursing and boarding care homes. Of course, we have our own members right here with Fran Sutcliffe and the nursing hotline patrol. We work very closely with the ombudsman program in Florida. From our office in Washington, we are in daily contact with our members across the country and their concerns and ideas.

For the past 10 years I personally have been involved in the long-term care field working as the long-term care ombudsman in Minnesota among other roles.

We especially want to thank you for the leadership and concern that you have shown for nursing home residents. You have demonstrated this by holding this hearing and bringing these issues to public attention. We believe the timing of this hearing was instrumental in Secretary Schweiker's decision not to publish the draft regulations that we had been looking at. We especially appreciate your willingness to hold this hearing before any such publication came out in the Federal Register. We think if the rules had actually been published and then had come to public comment, the hoopla would have been so intense it would have been very embarrassing and time consuming for everyone.

So, we really appreciate your role in all this.

As you mentioned, we have been working very hard on this issue. We have alerted the public to the devastating effects of these

proposals. We have developed a statement in conjunction with the National Association of Social Workers which 39 other major national organizations signed and that was delivered to Secretary Schweiker on March 12.

The signatures were from such groups as the AARP and UAW, and the International Association of Fire Chiefs. So, we did have a lot of support in this; however, the HHS officials did decline to meet with us to discuss our concerns. While we applaud the Secretary's action of finally withdrawing the rules, we must point out if HCFA had involved the groups affected in the process of development of these rules, if they had sought our advice, our opinion, and the opinion of these other organizations that were affected, much of the controversy surrounding these rules would have been avoided in the first place.

We think it is extremely important to make the public aware that the HHS is still considering some major changes in the rules and regulations regarding nursing homes, but these changes are in the inspection process, which outlines the role of State surveying agencies who certify medicare and medicaid nursing homes to receive public money. We have been told that such a rule will be issued in the next few weeks. We are terribly alarmed at the direction that has been suggested by the earlier proposals that we have seen in the survey and certification area.

While HCFA may be planning to make some modifications of the draft we looked at, we still understand that many of the elements we are concerned about are going to be included in this new proposal that will be coming out in a couple of weeks.

Three particular areas that we are concerned about are: One, allowing deemed status for medicare and medicaid homes who are accredited by the Joint Commission on Accreditation of Hospitals. The second area is going to a flexible survey cycle. (Right now we have an annual inspection on nursing homes.) There is discussion now of going to every 3 years. The third area that we are concerned about is eliminating the followup visits to facilities that are presently required.

I just have one other comment to make in my preliminary remarks here about the role of regulations. I think it is important to restate what that role is. We have heard here how long-term care demographics are changing. We also are aware of how nursing home care can affect practically everyone. If you are not going to be there yourself, you are certainly going to have a relative or a friend that is going to need that kind of care. You are going to be drawn into it at some point in your life. So, we believe that the public ultimately shares an interest in seeing to it that the quality of service is provided.

We have to say that present regulations represent only minimal requirements and good homes, obviously, and the administrators you have had before you today, do not resent those kinds of minimal requirements since they believe they should be doing that anyway.

Regulations are still, basically, enforcement mechanisms. They are most helpful in two ways. As guidelines for conscientious care providers, and as enforcement tools to be used when certain facilities continue to provide negligent care. Though we have noted that

improvements have been made in many homes in the past few years, there are still many facilities which do not meet community standards, and that is evidenced by the kind of complaints that the ombudsman program is getting and the kind of things that the woman from SRS here was talking about. We know that because there is not enough in home long-term care, and there are shortages of nursing home beds, you cannot move to another bed if you do not like where you are. So we know that residents are going to continue to have to live in the substandard facilities and we believe that a strong enforcement role is still going to be needed to provide the nursing home residents, the concerned citizens and the taxpayer public with protection and accountability for hard-earned dollars.

At a time when medicare and medicaid costs are expanding rapidly, public spending is being more closely examined and the taxpayers are demanding more accountability for their money, we need assurances that the proposals for surveying and certifying nursing homes will not backtrack from the current minimal enforcement mechanisms that we have right now.

I would be happy to answer any questions that you have.

[The prepared statement of Ms. Parker follows:]

TESTIMONY

FOR THE NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM
BEFORE THE U. S. SENATE LABOR AND HUMAN RESOURCES COMMITTEE

SUBCOMMITTEE ON INVESTIGATIONS AND OVERSIGHT

Senator Paula Hawkins, Chairman

1982 MAR 15 PM 2:01
SEN. PAULA HAWKINS
WASHINGTON, D.C.

March 22, 1982

Madam Chairman, thank you for this invitation to testify before you today.

My name is Pamela J. Parker. I am representing the National Citizens' Coalition for Nursing Home Reform. Since 1977, I have served on the Executive Committee of the Board of the Coalition. We represent over 110 citizen organizations and agencies in 32 states who are actively involved in efforts to improve the quality of care and life for persons residing in nursing and boarding care homes. From its office in Washington, D. C. the Coalition is in daily contact with the concerns and ideas of its members across the country. For the past 10 years I have been working and involved in the long term care field, first as a Medicaid caseworker in a large metropolitan county in Minnesota, then as Director of the Nursing Home Residents Advocates Program in Minneapolis and most recently as Long Term Care Ombudsman for the Minnesota Dept. of Public Welfare and the Minnesota Board on Aging.

NCCNHR appreciates this opportunity to present our views on proposals presently being drafted to revise the current conditions of participation and certification/survey methods for Medicaid and Medicare Nursing homes. Since early December, when the public became aware of these proposals, our Washington office has been deluged with calls and letters from our members and diverse segments of the public - individuals expressing shock, outrage and opposition to the general tone of these proposals. These proposed changes stem primarily from the work of the HCFA Task Force on Regulatory Reform chaired by Dr. Paul Willging. In the past few months we have reviewed several draft proposals which have been circulated to various agencies in HHS, the latest dated Feb. 22, 1982. According to these drafts, the purpose of the regulatory reform efforts is to preserve if not strengthen those provisions which deal with actual care provided to nursing home residents and to minimize procedural burdens imposed on nursing home managers. Although the regulations are in draft form and subject to change it is important that the present trend to reduce the effectiveness of current federal responsibility be interrupted before publication in the Federal Register as a Notice of Proposed Rule Making (NPRM). It has been our experience that few changes are made in proposed regulatory language in spite of public response once it is published in the register.

We see no evidence that the result of these changes will lead to improved patient care and quality of life. We believe the cumulative effects of these changes will result in accelerated deterioration of nursing home residents requiring more costly care, and increases in fraud and abuse incidents.

Present regulations represent only minimal requirements. Good homes should not resent minimal regulation since they should be providing such services anyway. But regulations are basically enforcement mechanism(s). They are most helpful 1) as guidelines for conscientious care providers and 2) as enforcement tools to be used when certain facilities continue to provide negligent care. It is a fact that though improvements have been made in many homes in the past few years, there are still too many facilities which do not meet community standards of care, as evidenced by complaints received and verified by Health Departments, Ombudsman Programs and citizens' organizations in communities across the country. Given the unavailability of in-home long term care services, shortages of nursing home beds in some areas, and discrimination against Medicaid recipients, many nursing home residents have no other choice but to remain in sub-standard facilities. Reducing basic minimal regulations simply gives license to poor facilities to become poorer and takes away the basic tools used by enforcers to cause facilities to change and take responsibility for their actions. Furthermore, reducing regulations and oversight deprives the frail nursing home resident, the concerned citizen and the tax payer public of protection and accountability for hard earned dollars.

The proposals we have reviewed are clearly a giant step backward when one considers the long social and legislative history that led to the development of current regulations in the 1970s and the documented weakness of the current system. They are certainly inconsistent with the evidence that has accumulated over the past 15 years from state and federal congressional hearings, scores of government studies and reports of voluntary organizations and the media. According to the Task Force for Regulatory Reform, current regulations exceed the intent of federal law. Yet to our knowledge, none of the numerous congressional hearings during the last 15 years has ever concluded that nursing home regulations are too strong. On the contrary, most hearings have raised issues regarding the need for strengthened accountability and a stronger enforcement system.

It is important to note that in July 1980, HCFA/HHS published a proposed nursing home regulation after considerable exchange among HCFA officials as well as the public, nursing home providers and health care professionals. This was a three year initiative (1978-1980) to review, simplify, and strengthen regulations which now appears to have been ignored by the Task Force. We question the wastefulness of ignoring that three year process and we emphasize the haste with which the proposed drafts have been developed. Although we felt the 1980 proposals could have been stronger in certain areas, they did reflect tremendous progress toward the advancement of the health and safety of nursing home residents especially in the area of patient rights. In comparison,

these 1982 draft rules reflect unbelievable regression in many areas. We also question the closed nature of the Task Force. Their meetings were not open to the public and in spite of early assurances that we would have the opportunity to be involved in the process, HCFA did not solicit our comments on these proposals.

We wish to share with you a position statement developed by NCCNHR in coordination with the National Association of Social Workers. To date 39 major national organizations have joined us in signing this statement. However, HHS officials have declined to meet with us to discuss our position statement. (See attached.)

We ask that this Committee continue to support a federal responsibility for ensuring protection of the quality of life and care for nursing home residents and strong accountability for public dollars spent on this. We hope that you will join us in requesting HHS to stop publication of these or similar draft regulations at this time. We thank you for the leadership and concern for nursing home residents you have demonstrated by sponsoring this hearing and bringing these problems to public attention.

I would like to outline some of our major concerns in two areas: The Conditions of Participation, and the survey and certification process,(SubPart S.)

CONDITIONS OF PARTICIPATION

1. Deletion of the Standard for Staff Development

Eighty to ninety percent of the care provided to nursing home residents is given by aides and orderlies. Yet only a few states require formal training for these personnel. Many of the most serious documented problems in nursing homes relate to the lack of training and orientation of nursing home staff. Present federal regulations are minimal, specifying that the facility conduct an ongoing staff education and orientation program covering the problems and needs of the aged, ill, and disabled, infection prevention and control and patients' rights. HCFA's proposal would delete this standard leaving only three brief, scattered, unspecified references to "staff development."

An early version of HCFA's draft analysis stated "the provisions regarding staff development would be deleted since they do not contribute directly to patient health and safety." That statement shows an unconscionable ignorance of universally accepted principles of care giving. We believe deletion of the present minimal requirements, coupled with financial pressures due to Medicaid cutbacks will lead many providers to cut staff training programs, eradicating many of the progressive gains made in the provision of care over the last few years and leaving nursing home residents further exposed to mistakes which result in physical and emotional harm.

2. Deletion of the Condition of Participation for Social Services

Residents and their families need special supports to assist them in the patient's reaction to and adjustment to institutional living.

Many residents suffer from depression, anxiety, withdrawal, anger, and remorse, and exhibit severe behavioral problems in an unfamiliar, sometimes sterile or even hostile, environment. Hundreds of residents are released from mental institutions into nursing homes. They need special support and counseling. Facility staff need help in developing and maintaining sensitivities toward residents, their rights, the special needs of ex-mental patients, and with death and dying.

Social service personnel in nursing homes currently provide these kinds of services, and they assist in identifying and arranging for services which may be available in the community.

Under HCFA's draft proposals a facility would not be required to provide or arrange for social services. The facility would have to identify psychosocial needs, but without specific staff trained and assigned to this task it is unlikely that these needs will be recognized, let alone addressed.

3. Deletion of Requirement for Activities Director

The capacity of nursing homes to be more homelike has increased in the last decade largely due to the considerable effort on the part of those who work on quality of life issues. With direction from trained staff and consultants, activity programs in many facilities have developed into an important therapeutic aspect of nursing home care. Activity Directors encourage residents to regain a sense of control, choice, and community by assisting with development of Resident Councils, Family Councils coordinating volunteers and other forms of community activity. These regulations would no longer require an Activity Director, or consultation to the activity program by any trained individual. This means that untrained workers could be placed in these positions or that activities programs could be provided entirely without trained staff specifically assigned. Though volunteer bingo, bible study, birthday and holiday parties are laudable efforts, they cannot replace a specially designed individual activity plan developed and monitored by trained staff. Deletion of this requirement will sentence many more residents to a life of vegetation before the television set.

4. Deletion of Medical Director Requirements

In deleting requirements for Medical Directors, HCFA once again appears to ignore the results of its own research. Findings of three recent research reports funded by HEW/HHS strongly support the value of the Medical Director who provides an essential role in the overall coordination of the medical care of the facility. The Medical Director ensures collaboration with other physicians who see their patients in the facility and develops and oversees the "rules of the house" which all physicians must abide by. The SNF, which is supposed to provide skilled professional care to sick people, would otherwise lack this kind of order and discipline which in a hospital setting is considered essential. Without a Medical Director there is no general supervision of patient care and the medical condition of patients. Many general practitioners

seldom visit nursing homes and many are not available in an emergency. A Medical Director with some experience and knowledge and interest in geriatrics is an important resource to the facility and to general practitioners who may have little knowledge of this field.

5. Patient Care Management System

We believe an interdisciplinary team approach to assessing patient care and progress is essential to meeting the total human needs of nursing home residents. Therefore, NCCNHR has supported the concept of a Patient Care Management System throughout years of research and study by HHS. However, despite several years of extensive study and a million taxpayers' dollars spent on this topic, HCFA has virtually ignored its own recommendations in this proposal. Because of reductions in other staff requirements and the lack of a specific nursing staff/patient ratio, the very existence of an interdisciplinary team in nursing homes may be impossible. In addition, all references to written care plans and assessment tools have been deleted from this draft, leaving this critically important concept in care delivery virtually meaningless. Therefore, we feel it would be irresponsible of HCFA to publish this portion of the regulations as a final rule as proposed in its Feb. 22 draft.

6. Weakening of Patients Rights Standards

Current patients rights regulations are a minimal reminder that, unless special precautions are taken, institutionalization, in spite of the best intentions, tends to dehumanize individual freedoms.

Countless documented abuses of the constitutional rights of nursing home residents and years of struggle led to the addition of a patients' rights standard to the conditions in 1974; this was recognized as a major advance by consumers, providers and legal advocates. These drafts weaken significant areas of patients' rights. The requirement that patients receive a quarterly accounting of their personal funds has been deleted. This appears inconsistent with congressional concerns about documented abuse of patients funds expressed during hearings about the passage of the Medicare Antifraud and Abuse Amendments of 1977 (PL 95-142) We believe deletion of this requirement will lead to an increase in patients funds fraud and abuse. In addition, patients would no longer have the right to participate in the planning of their care. Instead, their participation or their families' in the PCMS team would be "as appropriate," in other words, at the discretion of the facility.

We fail to understand the basis in which this Administration appears to object to the strengthening of the rights of elderly and handicapped nursing home residents. On January 19, 1981, Patricia Harris signed regulations which would have elevated patients rights to a condition of participation within the regulations instead of one of many standards under a broader heading. January 20, 1982, that regulation was rescinded by HHS officials and later affirmed by the then Acting Secretary Schweiker. Now HCFA proposes further deletion of these rights. This Administration should act positively to ensure the basic human rights of elderly and handi-

capped nursing home residents by upgrading them to a full condition of participation.

7. Nursing Services and Drug Administration

We are also concerned about deletion of references to rehabilitative nursing standards and allowance of a two percent error rate in administration of drugs. This means that a facility having a resident count of 150 residents who are receiving an average of four drugs or biologicals apiece during a 24-hour period (a very low estimate) would have "600 opportunities for drug administration error." At a drug administration error rate of two percent this facility could perform twelve "drug administration errors" in a 24-hour period or 4,380 per year and still be in compliance for Medicare or Medicaid certification. No distinction is made about types of errors (i.e., received at wrong time, wrong drug, or not received at all). Our members, particularly those in the nursing profession, find this ludicrous given current acceptable nursing practice standards.

SURVEY AND CERTIFICATION (SubPart S)

We are extremely alarmed at the direction suggested by the changes to SubPart S (survey and certification of Medicaid and Medicare facilities). At a time when Medicare and Medicaid costs are expanding rapidly, public spending is being closely examined, and taxpayers are demanding more accountability for their tax dollars, this proposal would decimate current minimal enforcement mechanisms.

1. JCAH "Deemed Status"

Under this proposal, accreditation by the Joint Commission on Accreditation of Hospitals (JCAH) could be substituted for certification of SNF's participation in the Medicare and Medicaid programs. Though states could choose whether or not to use JCAH accreditation for Medicaid certification, they would be required to accept JCAH for those facilities participating in the Medicare program.

As we understand it, JCAH is a private non-profit organization governed by the American Hospital Association, the American Medical Association, the American College of Physicians and Surgeons and the American Dental Association based in Chicago. JCAH now accredits about 1300 Long Term Care facilities including about 600 hospital based SNF's. Nursing homes pay JCAH application and survey fees for the privilege of accreditation. The survey is pre-announced and based on a self assessment check list sent in advance to the facility. Its results are not available to the public through JCAH, although the facility can make them available. Consultants from other nursing homes are sometimes used to conduct surveys.

NCCNHR has no objection to the programs of JCAH as they now stand. We do, however, question the wisdom of using JCAH as an enforcement agency on a number of grounds.

A). In our discussions with officials of JCAH we were informed that "JCAH does not and never will regulate," and that it is the responsibility of the government to regulate or enforce the standards.

We agree that enforcement is appropriately a government role and should not be shifted to a private body that is not responsible to the public. Inspection surveys are the only means the public and the nursinghome residents have to assure that the 20 billion dollars they spend annually on nursing home care are being spent appropriately on quality services. However, we believe the proposal we've seen would place JCAH in an enforcement role, at the same time reducing the regulatory role of the federal government and the state survey agencies. IfJCAH cannot or will not regulate, does this mean that states or federal agencies must continue to perform this function? If so, why utilize JCAH services in the first place?

B). We recently conducted a survey of state licensing directors requesting their views and experience with JCAH and other aspects of the enforcement system. To date, 29 have replied. Everyone of them expressed concern and/or opposition to the JCAH proposals citing potential for duplicative administrative systems. weakened or restricted state endorcement authorities, lack of public accountability, conflict of interest, lack of follow-up and increased costs under these proposals. Despite continued objections raised by the National Association of Health Facility Licensure and Certification Directors this proposal appears likely to be published. Drafts of this proposal have not been shared (to our knowledge) by HCFA with the states we have contacted. State agencies are now receiving major cuts in their Medicare and Medicaid survey and certification budgets. Additional cuts are anticipated. Does it make sense to add costs of a JCAH accreditation process to the Medicaid budget and at the same time reduce state enforcement budgets?

C). What recourse will the public have if JCAH accredits a facility about which it is concerned? How will a Chicago-based organization with no regional offices, routinely and responsively handle ongoing day-to-day concerns and complaints from the public? At least one state licensing agency has informed us that JCAH's method of dealing with consumer complaints in his area is through the mail. How would instances of abuse and neglect (which unfortunately still occur frequently in many states) be identified through only occasional surveys? And finally, of major importance, how will objectivity be insured when JCAH is dependent on payment from the facility for its accreditation services?

2. Other SubPart S Changes

In other changes to SubPart S, HCFA proposes to extend the survey inspection schedule to a flexible cycle of up to three years based upon the facilities' compliance history. HCFA also proposes to eliminate the requirement for an on-site follow-up visit to

ensure that major deficiencies have been corrected. Such visits could be replaced with telephone or mail verifications. Routine quarterly staffing reports would also be eliminated under the proposals we have reviewed. We are aware that ownership changes, personnel changes and other variables can produce a very crucial shift in the quality of care provided in a facility. How can we as taxpayers, friends and relatives of nursing home residents and potential consumers, justify providing continued reimbursement to facilities without checking more often than every three years to ensure that people are getting the services paid for?

HCFA has also reduced the number of Conditions of Participation by making some conditions into standards within other conditions. We understand that there are no set guidelines for Regional HCFA office decisions as to how many or which standards within a condition must be out of compliance before sanctions or decertification are recommended. Many important standards may lie within one condition (e.g. all drug administration standards are within the Nursing Services Condition.) Reduction in the number of Conditions without clarification as to what will constitute cause for decertification may serve to further weaken the regulations.

HCFA also asks for comment on the concept of allowing facilities licensed under state programs "deemed status" for Medicare and Medicaid. We would point out that state licensure and enforcement systems vary drastically state-to-state, and that many states are currently experiencing major budget cuts in their licensing programs, which are interrelated with the federal certification process and heavily dependent on federal funds. It is unrealistic to expect the states to pick up added responsibilities without additional funding.

We cannot think of any circumstance which would justify a federal abdication of some role and responsibility in ensuring that residents of nursing homes across this nation are cared for properly. Though HCFA anticipates cost savings due to further cuts in state certification budgets, we do not see how greater scrutiny of nursing home services and financial activity will result in greater costs to the federal government. Rather we believe more scrutiny will constrain Medicaid and Medicare costs by identifying fraudulent claims, encouraging efficient use of public dollars, and ensuring that appropriate services are provided to nursing home residents.

THANK YOU.

Senator HAWKINS. Thank you. I must commend one so young for having 10 years experience.

Ms. PARKER. Well, I am older than you think.

Senator HAWKINS. We are really proud of all of the many things you have done. You are such a wonderful resource of information for us as we have been putting together our thoughts on this subject.

Could you tell me why you are concerned about the Health Care Finance Administration's proposal to allow the JCAH, Joint Commission for Accreditation of Hospital facilities "deemed status" under medicare and medicaid? Could you tell me why?

Ms. PARKER. Yes. I need to go back a little bit in the history and just mention that in 1980 the Healthcare Finance Administration held a number of hearings around the country on proposals to change the survey and certification process. They called this the "Sub-part S hearings." They issued a number of discussion papers asking for comments from the public on these things. While some of the things HCFA is proposing right now were included in that paper, I want to make it clear they did not ask for comments at that time on going toward this accreditation deemed status with JCAH. So, we really have not had much public discussion, at least in an open forum, of this issue.

JCAH is a private, nonprofit organization governed by the American Hospital Association, the American Medical Association, the American College of Physicians and Surgeons, and the American Dental Association. It is based in Chicago. As we understand it, they now accredit about 1,300 facilities around the country. Nursing homes pay JCAH an application fee for the privilege of accreditation. There is a preannounced survey and it is based on a self-assessment checklist. Its results have not been available to the public in the past. They also sometimes use people from other nursing homes to help them in their survey process.

Now, we have no objection to the programs of JCAH as an accrediting body. But what we are concerned with is mixing the role of the private organization with the Federal responsibility and State responsibility of regulatory enforcement. We believe that the particular proposals that we have seen and the particular proposals that we understand are still being seriously considered for publication in the rule, in looking at those things, we believe that they will have the effect of trying to put JCAH in an enforcement role or regulatory role. We understand JCAH does not want to be a regulator, and we are glad. That is fine with us.

We share that same view, that they should not be a regulator, but we feel that these proposals will put them in that stance. We do not think that is going to work.

Senator HAWKINS. How would the proposal to allow JCAH deemed status affect the consumer if he wishes to make a complaint, for instance?

Ms. PARKER. That is one of our major concerns. First of all, I need to point out that the Federal Government had actually decertified facilities which were still JCAH accredited. So, there has been disagreement in the past between the Federal Government, the State governments, and the consumers that are going to be affected by those surveys with JCAH on particular facilities.

We had the opportunity to discuss with an official of the Joint Commission how they would handle complaints from consumers. They told us they presently receive very few complaints from consumers. Most of the follow up they do is done by mail or by telephone, or they come around about every 2 years and they will let the consumer who is complaining know when they are going to be there next, and then they will set up a meeting. Obviously, that is not going to be timely for the kinds of complaints we are dealing with. They have no regional offices. We don't believe they are going to be equipped to handle the kinds of abuse and neglect complaints that could come up.

Now, the official from JCAH, to give him credit, did say that he thought that all of this needed some major studying in terms of how they would handle complaints. He did say he expected they would refer those complaints to the State survey agencies and yet we are, as you have heard already, reducing the State's role in this in terms of the survey and certification budget. We are afraid the States are not going to be equipped because of their budget crunches with the money, the resources and the staff to be able to go out and deal with those complaints either for those JCAH facilities. So, we do feel that the consumer's ability to make a complaint and to have that responded to in a timely fashion and in an effective fashion is certainly going to be diminished.

The last thing that I would mention on that is also the objectivity. We are very concerned as to how, when JCAH is dependent on a facility for a payment, how that survey is going to be objective—how that complaint investigation is going to remain objective. It seems to us there is little incentive there for followup.

Senator HAWKINS. Floridians now have access to a nursing home survey reports through the public libraries. I do not know if everybody knows that or not, but these are available.

How will consumers get access to information on homes that have been surveyed by the JCAH?

Ms. PARKER. We have been asking that question of HCFA for quite sometime. We understand that they have gone through quite a long negotiating process with JCAH about that very thing. We have documents which show the letters back and forth. We understand that HCFA would probably require the nursing home itself to post the Survey Report because the JCAH still maintains their reports are confidential.

The problem with that is that consumers, because they would not have any role in how JCAH operates—I understand JCAH does have one consumer representative on their board, and perhaps others on committees, but let us say consumers are not widely involved. So, they would not have any control over how the report would be formulated. For instance, would it be in terms that the public could understand? I understand some of their information is coded. Now, if it were posted, would it mean anything to us anyway; would the value of the information there be comparable to the information that we are getting now? We are also concerned that some facilities may refuse to make those reports available. Of course, that would cause a problem. They would perhaps lose their status with the JCAH, but it might take quite awhile for that to

come about. In the meantime, the consumer still does not have any information.

Senator HAWKINS. How do you feel about HCFA's proposal to extend the annual survey inspection schedule cycle up to 3 years?

Ms. PARKER. Particularly if that proposal is coupled with the proposal to go with JCAH, that is going to cause problems. We can foresee that even though a facility may be good and may be assigned to a 3-year schedule or just to being in a sample population, where they just might sample a few facilities, we can foresee—since the average stay of a nursing home resident in a nursing home is about 2 years, what we can see happening is there may be a change after the first survey, (even though regular surveys are scheduled every 3 years) there may be a drastic change in care, and it may be several years before anyone catches up with the changes in care that are causing severe problems in that facility. In the meantime, residents may live the rest of their lives in a facility that has not had any monitoring at all by any regulatory agency.

We think, of course, it is going to shift a lot of the responsibility to individuals and the public that is walking in and out of those homes to make more complaints and to demand some response to those complaints, but that happens in some areas, but it does not happen in other areas because people are still very afraid to make complaints. They do not know how to make complaints and they do not always——

Senator HAWKINS. They do not know where to make complaints.

Ms. PARKER. And they do not know where.

Senator HAWKINS. What do you think the overall affects of the JCAH and other changes will have on the safety and health of nursing home residents?

Ms. PARKER. Well, we asked that question of the States and we did a State survey which showed—we got 29 responses back from the State Survey and Certification Agency Licensing Divisions. They were very negative. In fact, almost all of them were not in favor of the JCAH part of the proposal. Many of them pointed out that they had already had to go to 3-year cycles and their budgets were being cut to the extent some of them were losing up to half of their survey staff. So, we feel very concerned about the overall effect of these proposals and we really cannot see that they are going to be cost-saving due to the cuts in the State certification budgets. In fact, we think greater scrutiny of nursing homes is needed to constrain medicare and medicaid costs by identifying fraudulent claims, by encouraging efficient use of dollars and assuring that appropriate programs and services are provided to nursing homes.

Our concern is that as medicare and medicaid costs increase that what we will be doing is sort of throwing money down an empty hole with no safeguards there at the bottom. The only way we have of knowing what comes out is the nursing home inspection and survey process. So, we think the course that is being considered may be pennywise and pound foolish.

[The material referred to follows:]

National Citizens' Coalition for
NURSING HOME REFORM

1424 Sixteenth Street, N.W.
Suite 204
Washington, D.C. 20036
202/797-8227

Freida E. Gorrecht
President

Elma L. Griesel
Executive Director

March 12, 1982

SURVEY OF STATE AGENCIES:

IMPACT OF FEDERAL POLICY CHANGES AND BUDGET CUTS

ON NURSING HOMES

In January 1982, NCCNHR sent a questionnaire to all the state nursing home regulatory agencies asking for information on the extent the federal budget cuts had affected their programs and their opinions regarding changes in nursing home regulations proposed by the administration (see questionnaire, Appendix II).

Twenty-nine states (see list, Appendix I) responded. Their answers are summarized in this tabulation of survey results. The responses came from states with a variety of socio-economic conditions representing a cross-section of the country.

State agencies were overwhelming in their concern that the proposed regulatory revisions and the federal budget cuts would have a serious and harmful effect on the quality of care and safety of residents.

Many states were unable to answer some questions related to proposed changes in federal regulations, noting that the federal government has not informed them, or consulted with them, in the process of developing these proposed changes.

Respondents demonstrated a sincere commitment to protection of the welfare of nursing home residents and expressed a general concern that residents' welfare could be endangered by new federal policies.

For more information, contact Barbara Frank or Elma Griesel, NCCNHR, 797-8227.

NCCNHR is a national, non-profit membership organization, founded in 1975, to improve the long-term care system and the quality of life for nursing home residents.

SURVEY RESULTS

1. To what extent are your licensure and certification programs interrelated?

While certification and licensure are technically two different programs, mandated by separate authorities, 27 of the 29 states responding to the survey have integrated these programs totally or to a large extent.

Certification is a federally mandated procedure whereby a facility is approved for reimbursement under Medicare of Medicaid.

Licensure is a state-run program whereby a facility is given state approval to operate.

All but the two states that indicated that the programs have been combined mentioned some of the following ways in which they were consolidated.

- they use similar regulations
- same staff carries out both functions
- facility is evaluated for both programs during the same survey
- same section, bureau or division of government

Only North and South Carolina have separated their programs entirely. Ohio noted that it conducts separate surveys.

Many states pointed out that this integration of the two programs has created a more efficient, cost-effective operation and has added to the enforcement ability in each separate function.

2. Please provide information on any budget cuts your agency has suffered. How much has your budget been cut in fiscal years 1981 and 1982? To what extent do you anticipate that your state funds will be increased to cover the loss of federal dollars?

Twenty-eight out of the twenty-nine states responding have experienced budget cuts due to a reduction in federal funds for the survey and certification program which enforces the standards of care for nursing homes. These reductions averaged 24.45% in FY 1981 and 45.4% in FY 1982 for Medicare among those states providing measureable data on the cuts (11 states for FY 1981 and 14 states for FY 1982). Reductions in Medicaid occurred to a lesser extent. (Due to the open-ended nature of the questions, many states provided information on the amount of cuts without specifying which program, which year, or what percentage of the total budget the cut represented.)

Only six states have seen an increase in state funds to make up for part of this loss. One state anticipates that increases in the state budget will totally absorb the loss of federal dollars. Three states have experienced state budget reductions as well as federal cuts. Fourteen states indicated that they have no expectation of state funds to cover the loss of federal funds.

3. What type of personnel changes have you had to make and do you anticipate having to make as a result of the budget cuts?

Every state agency except Indiana responded that it has lost staff, and in the case of all but four states, agencies have had to lay off surveyors to absorb the cut in funds. Three of these states did not fill vacant positions or forced retirement-aged employees to retire. Five have left vacated positions unfilled.

State agency loss of personnel ranged from 15% to 50% with one state losing all of its full-time personnel. The median loss among states that specified percentage of staff cut was 22%.

4. Given personnel changes, what changes do you anticipate in how you conduct your programs?

Twenty-four states have had to make program changes in response to the budget cuts and subsequent personnel loss. Of these, seventeen now conduct surveys less frequently, many on a less than annual basis.

Eleven states have shortened their surveys, many instituting modified surveys using key standards and elements to determine whether or not a more thorough survey is necessary.

Five states noted that they are using smaller teams; four other states indicated that they are relying more on generalists instead of specialists. Five states named Life Safety Code evaluations as a main area for reduction in survey emphasis.

On-site follow-up visits to determine if facilities have corrected their deficiencies have been replaced by telephone and letter verification in ten states.

Nine state agencies have also reduced their consultation to facilities or eliminated this service entirely. Some noted that it is this consultation which can prevent minor problems from becoming serious situations.

One state indicated that it is starting to conduct inspections by sampling residents rather than surveying each resident.

Another state now only responds immediately to those complaints which are life-threatening.

5. What would be the effect of proposed changes in Subpart S being considered by the Task Force, such as flexible survey cycles, elimination of on-site follow-up requirements, and others?

State agencies had mixed reactions to the potential effects of proposed changes in the survey and certification process. Five states opposed the proposals as detrimental to health, safety and quality care for residents. Three other states, where some of these proposals are already in place, also found the

changes harmful, one citing a rise in the number of complaints the agency is receiving.

Ten states indicated that they have already implemented the changes and two of these rated them as changes for the better.

Two states voiced support for the proposals in general. Most states which supported changes in Subpart S did so with regard to the flexible survey cycle. Seven states support this concept and another two states oppose a less than annual survey cycle. One of the states supporting less than annual surveys did so on the basis of financial realities. Others who supported institution of a flexible survey cycle stressed the importance of state authority to determine when a survey is necessary. One state foresees flexible surveys as potentially useful as an incentive for good care, but potentially harmful as a relaxation of oversight.

Quarterly staffing reports were called unnecessary by one respondent who supported their elimination. Another state called for elimination of Medical Care Evaluation Studies.

One state indicated that it will maintain its own enforcement system regardless of federal relaxation of standards.

6. What changes in Subpart S do you think are needed to improve the survey and certification process?

Fifteen of the states responding to the survey had suggestions for changes in Subpart S. Six respondents indicated their support for flexible survey cycles; two of the six noting that this would allow them to concentrate on facilities with a history of bad care. Four respondents stated that any changes should result in greater flexibility for the states, one of the four pinpointed a reduction in paperwork as a desirable objective.

One state raised the issue of on-site follow-up visits and expressed mixed feelings about the option of using other means for verifying correction of deficiencies. This respondent saw the value of the proposal in terms of cost-savings but expressed concern that it could result in a deterioration of care.

Another state favored elimination of the RN waiver and a third state noted opposition to deemed status for the JCAH (see question 8 for elaboration on state agencies' view of JCAH deemed status).

7. How many nursing homes in your state are accredited by the JCAH? Generally, how do JCAH findings compare with your findings in each home?

Eighteen of the twenty-nine respondents have nursing homes accredited by the JCAH in their states; though for the most part the number of accredited facilities is nominal. Twelve states answered that they have very few or less than ten facilities, another four counted less than twenty JCAH-accredited homes and two states mentioned higher figures (Ohio counts less than 50 homes and South Carolina says that 70 out of 119 homes are JCAH-accredited).

Asked how JCAH survey results compare with their state licensure and certifi-

cation findings, twelve respondents could not make this comparison, nine of them noting that they did not have access to JCAH survey findings. Another eleven states said they did not know or hadn't conducted a formal comparison.

Three states cited instances in which the state found significant problems in facilities which were accredited by the JCAH.

Two states felt that JCAH homes are generally better facilities while one state found them generally worse.

8. Would you support federal regulations which authorize deemed status for JCAH for Medicare facilities? Explain.

Twenty-six out of twenty-nine respondents oppose use of JCAH accreditation for certification under Medicare. The three which supported the idea did so only on the condition that JCAH survey results be available to the public.

The following chart lists the objections raised by respondents and the number of persons who mentioned each concern:

Objection	No. of times mentioned
Reputation of JCAH or of JCAH facilities	12
JCAH's complaint handling record	5
JCAH standards of care	5
Lack of authority to carry out enforcement program	5
Inappropriate role for JCAH	5
Limits effectiveness of state enforcement system	4
Enforcement of standards of care is a state responsibility	4
JCAH less than annual survey cycle	4
Conflict of interest because of fees paid by nursing home to JCAH	3
Concern because JCAH is out-of-state	3
History of and capacity for JCAH follow-up on deficiencies	3
JCAH surveys are announced	3
Concern over JCAH accessibility because it is out-of-state	2
Costliness of proposal	2
JCAH track record in long term care	1

Respondents encouraged the federal government to grant deemed status to state licensure units instead of the Joint Commission on Accreditation of Hospitals.

9. Do you believe there would be a cost-savings in the survey-certification program if JCAH or any other accreditation body has an official role?

Twenty-five respondents do not think deemed status for the JCAH will save money. Two say it is possible and one doesn't know. Seven respondents believe use of JCAH accreditation will actually increase costs, six believe it will have hidden costs, five foresee that costs will be passed on to the public in one way or another.

Five respondents indicate that there will not be a cost-savings because the proposal will essentially add to the current survey costs incurred by the states.

Two states object to sending survey money out of state and two others question what accountability JCAH will have to the states. Another suggests that because JCAH is out-of-state, states will have no control over the quality of the service JCAH provides.

10. Does your state Medicaid program currently reimburse facilities for their participation in the JCAH program? If so, how is this paid- as an educational expense item or an administrative expense or other?

JCAH costs are a reimburseable item in ten states which responded to the survey, but not in fifteen others. Three respondents don't know and another did not comment. In eight states it is reimburseable under administration, in one as patient-related and in one as an educational cost.

11. Will major changes in the Conditions of Participation have a negative or positive impact or no impact at all? Please explain.

Twelve respondents believe federal relaxation of standards will have a negative effect. Three respondents feel it will have no effect because of the strength of state laws and two say that changes which improve patient care could be positive. Ten states didn't know what the effect will be, eight of them indicating this is because they have not yet seen a copy of the proposal or been informed of its contents. Two other states had no comment.

Seven states expressed concern that the changes might harm patient care; two expressed concern that changes might lead to reductions in state standards.

Four states hope to see improvements in enforcement conditions and one hopes the changes will reduce the paperwork burden.

12. What changes in the federal Conditions of Participation and Subpart S do you think are needed to improve the regulations and to help assure their implementation?

Of the twenty-two survey respondents who commented on this question, three

thought there should be no changes in the current nursing home regulations. Most of the other respondents offered suggestions for improvement in nursing home regulations that were general- eight respondents hope to see more outcome-oriented regulations and another six want the regulations to maintain a good level of patient care.

Six see the need for improved enforcement regulations. Two ask for less paperwork and two want the regulations streamlined, one suggesting combining SNF and ICF standards. Another feels the regulations should be more specific to provide for more effective enforcement.

Among the specific suggestions relating to standards of care, three respondents support stronger residents rights, one respondent stated the need for better safety standards, and one suggested flexibility in physician visits, use of nurse practitioners, elimination of utilization review and elimination of specific physician visit requirements.

In the area of enforcement, three respondents endorsed flexible survey cycles, another three supported elimination of quarterly staffing reports, and one urged that states be granted deemed status for their licensure inspections.

13. Are any regulatory or legislative revisions currently in progress or under consideration in your state? What are they? Will they lead to a strengthening or a weakening of the standards? Please explain.

Seventeen states are currently undergoing some revision of laws or regulations for nursing homes and twelve stated that they are not undergoing changes. Of the seventeen who are, eleven expect these changes to be an improvement and two believe that they will detract from current rules.

In the area of enforcement, five states are considering establishment of alternative enforcement mechanisms or other means of strengthening the enforcement system. Seven states specified other changes under consideration. These include the following proposals, each mentioned by one state:

changes in the enforcement system in keeping with Subpart S waivers available from the federal government in the face of budget cuts; consideration of JCAH deemed status; clarification of regulations, reduction of paperwork (mentioned by two states); revision of regulations so they are more outcome-oriented and flexible; strengthening transfer protections; and establishment of a single level of care.

Two states foresee that a relaxation of their regulations may follow the federal example.

APPENDIX I

LIST OF STATES RESPONDING TO NCCNHR QUESTIONNAIRE

Alabama
California
Delaware
Florida
Hawaii
Illinois
Indiana
Kentucky
Maine
Maryland
Minnesota
Missouri
Montana
Nebraska
New Jersey
New Mexico
North Carolina
North Dakota
Ohio
Pennsylvania
Rhode Island
South Carolina
South Dakota
Texas
Utah
Washington
West Virginia
Wisconsin
Wyoming

By Regions:

Region I

Maine
Rhode Island

Region II

New Jersey

Region III

Delaware
Maryland
Pennsylvania
West Virginia

Region IV

Alabama
Florida
Kentucky
North Carolina
South Carolina

Region V

Illinois
Indiana
Minnesota
Ohio
Wisconsin

Region VI

New Mexico
Texas

Region VII

Missouri
Nebraska

Region VIII

Montana
North Dakota
South Dakota
Utah
Wyoming

Region IX

California
Hawaii

Region X

Washington

APPENDIX II

NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM
Survey of Federal Nursing Home Regulatory Changes
January 14, 1982

Name _____ Office Phone _____

Agency _____

Address _____

City _____ State _____ Zip Code _____

If you have not yet received a copy of the Draft of the HCFA Proposed Conditions of Participation and would like us to send one to you please check here _____.

Survey Questions

1. To what extent are your licensure and certification programs interrelated?

2. Please provide information on any budget cuts your agency has suffered. How much has your budget been cut in fiscal years 1981 and 1982? To what extent do you anticipate that your state funds will be increased to cover the loss of federal dollars?

3. What type of personnel changes have you had to make and do you anticipate having to make as a result of the budget cuts?

4. Given personnel changes, what changes do you anticipate in how you conduct your programs?

5. What would be the effect of proposed changes in Subpart S being considered by the Task Force, such as flexible survey cycles, elimination of on-site follow-up visit requirements, and others?

6. What changes in the Subpart S do you think are needed to improve the survey and certification process?

(Over)

7. How many nursing homes in your state are accredited by the JCAH? Generally, how do JCAH findings compare with your findings in each home?

8. Would you support federal regulations which authorize deemed status for JCAH for Medicare facilities? Explain.

9. Do you believe there would be a cost-savings in the survey-certification program if JCAH or any other accrediting body has an official role?

10. Does your state Medicaid program currently reimburse facilities for their participation in the JCAH program? If so, how is this paid - as an educational expense item, or an administrative expense, or other?

11. Will major changes in the federal Conditions of Participation have a negative, or positive impact or no impact at all? Please explain.

12. What changes in the federal Conditions of Participation and Subpart S do you think are needed to improve the regulations and to help assure their implementation?

13. Are any regulatory or legislative revisions currently in progress or under consideration in your state? What are they? Will they lead to a strengthening or a weakening of the standards? Please explain.

Thank you for your assistance. Please use extra paper as needed. Please return to NCCNHR in the enclosed self-addressed stamped envelope by January 29. If you have any questions call 202-797-8227 and speak with Elma Griesel or Barbara Frank.

Senator HAWKINS. Thank you so much. We are going to look forward to working with you as these developments proceed and your insightful analysis of the proposed revisions and, hopefully, abandoned revisions, still leave a lot of area for us to work with in the future on monitoring the long term care of the elderly.

We thank you for helping us and coming today.

Ms. PARKER. Thank you.

Senator HAWKINS. On behalf of the Florida Nurses Association, we will now hear from Mrs. Virginia Haggerty. She is going to enter her statement that she has for the record. She is the Executive Director of the Florida Nurses Association, and she is from my home area of Orlando.

We welcome you here, Mrs. Haggerty.

We often hear of nursing shortages within long-term care institutions.

Could you tell me what, in your opinion, are the causes of these shortages?

STATEMENT OF VIRGINIA HAGGERTY, EXECUTIVE DIRECTOR, FLORIDA NURSES ASSOCIATION

Mrs. HAGGERTY. Certainly, Senator Hawkins.

Thank you very much for the opportunity to come here, by the way, and speak with you and to recognize the activist role you are playing on behalf of the Florida citizens. We are very pleased at how sensitive you are to the problems Florida is facing. We believe they are unique to Florida.

Nursing staffing shortages are being experienced throughout the country, but we believe they are more acute in the Sun Belt States and more likely here in Florida. There is a lot of research data that has been conducted over the last 4 to 5 years that asks, "Why is there such a shortage of nurses?" In fact, there is a shortage of nurses.

Most of the data seems to be coming back saying there is a shortage of nurses who are willing to work in certain areas. Those areas are predominantly acute-care institutions and in nursing homes. Many, many studies have been done, notably in California, surveying why nurses are leaving institutions, what reasons are they giving, in Texas and again here in Florida. In fact, in Florida, the Florida Gulf Health System Agency conducted a survey of registered nurses in 1978 and 1979 and published their report, I believe, in 1980.

This was a very interesting study because they looked at not just one occupational setting of nurses in hospitals, but they separated out the data to look at nurses from nursing homes. They basically said to them, "What are the major areas of dissatisfaction; why are you either not working there or leaving employment in nursing homes?" The most significant problems that were identified by those nurses from this basic area were first of all low salaries, not being paid very well.

Second, poor staffing ratios. Third, poor fringe benefits. Then, things I think are more important, which would be limited opportunity for professional growth and limited opportunities for advancement.

The St. Petersburg Times from the 28th of February of this year reports that nurses working in nursing homes earn on an average of 15 to 30 percent less than their peers who work in hospitals. So, as we are saying, "Nursing Homes," we really are, I think, putting out an unrealistic expectation that there will be nursing care provided in those nursing homes.

We apparently are not willing to pay nurses to work in nursing homes.

We have heard testimony here today that the majority of complaints issued by patients and families relate to the direct patient care, nursing care items. We must make a conscious decision to pay to have nurses giving nursing care in those areas if we want to correct those situations.

Senator HAWKINS. Do you have a profile of the average nurse that would work in a nursing home?

Mrs. HAGGERTY. Right now it would appear that the nurses who are working in nursing homes are predominantly older. They are, again, either retired nurses with husbands who have stopped being the primary wage earner or they are single widowed women still supporting themselves and whatever family they have left.

Senator HAWKINS. When you say they are paid less—how much less are they paid?

Mrs. HAGGERTY. Almost 30 percent less.

According to your local papers, between 15 and 30 percent. The 30 percent differential probably relates to the investor owned high technology hospital acute care, coronary care units. However, I think it is very important for us to realize that the nursing care problems that are presented in nursing homes are just as acute and as complex as they are in hospitals. In fact, sometimes they are much more so because they are subjected to less care for medical monitoring.

Senator HAWKINS. What do you think can be done to change the negative attitude that nurses have toward elderly patients besides, raising the wages 30 percent?

Mrs. HAGGERTY. There are many things that we have heard today. There needs to be some societal changes and that is very, very true. As a society, we have difficulty accepting some of the idiosyncracies of the elderly. That is very broad based.

In the nursing profession we have been committed, for many years, to incorporating what we call "Development over the Life Span" in all nursing schools' curriculum. In fact, here in Florida that is being enforced as part of the regulations of the Florida State Board of Nursing.

Every program that prepares nurses must have some of their experience in—well, let me say, with elderly patients.

Now, part of the problem we are seeing arise is that certain groups are saying that the nurses—or that the student nurses, the potential nurses, are being given that experience very early in their nursing career and so we have a young 18- or 19-year-old male or female going into a nursing home and being totally—can I say wiped out—by the experience of caring for an incompetent, incapacitated senile patient. We need to look very much more at spreading experiences throughout all nursing school programs so that we have experience not just with the ill elderly, but the well

elderly in the senior citizen centers, and also with nursing homes. We are doing something about that now, but we are not doing enough.

We have many, many attitudinal studies that have been done that show if you put nursing students or nurses, in fact, into proximity with elderly patients over a fairly prolonged period of time and in a structured environment, the attitudes do change very significantly for the better. It is a matter of experience.

Senator HAWKINS. Part of the problem, as I see it, is that we have isolated each generation. We don't commingle as our families once did. Prior to my generation, your grandmother lived with you and grandmother took care of the grandchildren. It was the extended family, not the nuclear family that I read about today. I know this possibly causes this attitudinal change to come about. When a nurse 20 years of age suddenly is faced with an elderly person, and he or she has had no interface with elderly persons all those many years, difficulties may arise. A lot of us were raised with our 91-year-old grandmother living with us or next door and saw the advancing years go by.

Is there some way that increased training of aides, for instance, could help, so that the full burden is not just on the nurse?

Mrs. HAGGERTY. I think that increased training can sometimes hold out a hope that is not real. Let me just digress a little bit to say that in our own organizations, some of our local chapters, most notably here in Tampa, are trying to interface with community groups such as, for example, the Tampa chapter has an Explorer's Girl Scout post associated with it and the nurses in that area use that volunteer time to take the basic girl scout explorer into nursing homes.

When we talk about more education for personnel and aides and other nontrained professionals, to solve the problems, I don't think that that can be.

What happens is that we are looking to increase the education of nonprofessional people and not increase the education of professional people.

You have heard the good doctor over here discuss the fact that physicians are improving and increasing your knowledge of geriatrics right now. The same is true with nurses. For example, we have had geriatric nurse training programs here in Tampa and in Miami for many, many years. I would hate to see us stop that trend and say, "Well, let us just focus on increased education for aides." However, education will always result in improvement, yes. It is good, but it is not the answer to the problem.

Senator HAWKINS. While I have you as a captive audience, I must tell you I did my own survey, while I was in the hospital recently, among the nurses. I discovered that in asking every nurse if she knew of another nurse that would like to go to work and was unable to go to work, it was interesting to me that a lot of nurses are out there that would go to work if they had adequate child-care facilities, at the hospital or at the nursing home, for their children. There is only one child care center in Orlando that kept children after the regular 9 to 5 shift. When it comes to nurses that have to work the next two shifts, they had no place to leave their children except at one particular center. Even that day care center penal-

ized the nurses. If they were 5 minutes late, they had to pay for an extra hour. They may have been 5 minutes late because some patient needed extra care.

One nurse kept telling me, "And that child care center is 14.2 miles from this hospital." So it has become an economic factor.

I wondered if you had explored that as Executive Director of the Nursing Association and if you will work with me on starting that.

Mrs. HAGGERTY. We would be delighted.

[The prepared statement of Mrs. Haggerty follows:]

PREPARED STATEMENT OF MRS. VIRGINIA HAGGERTY ON BEHALF OF THE FLORIDA NURSES ASSOCIATION

Any discussion of health care needs in Florida, present or future, must begin with an understanding of the unique characteristics and trends of Florida's population.

The most notable "change" in Florida's population during 1970-80 was in the phenominal growth rate. An increase of 3 million people made Florida the third most rapidly growing state in the nation - a growth rate of 43.4%. Florida's 1980 census of 9,739,992 made it the seventh most populous state in the nation. More striking than these phenominal increases however is the dramatic "aging" of Florida's population. In 1980, 1.6 million or 17.3% of all Floridians were 65 years of age or older, this compared to a national average of 11.2%.

The median age, 34.7 years of Florida's population is almost five years older than the national median of 30.0 years. While statistians have for some time been aware of the increasing proportion of the U.S. population over age 65, Florida's in-migration of elderly retired has accelerated this trend to make Florida a "living laboratory" of what the future holds for the entire nation.

The 1980 Census figures reveal 1.7 million Floridians over the age of 65. Age itself, is not a determinate of the need for health care. As our knowledge of the aging process increases we are redefining our concepts of "the elderly" into the "young retired", "the frail elderly" and the "incapacated elderly". The specific needs for health care are largely related to where in this continuium the individual is presently located. The importance of this concept is most evident when we consider Florida's health care needs. For many years the vast majority of Florida's residents over 65 were just that -- barely over sixty-five. By and large an active retired group, their needs were answered by the development of community based facilities providing social interaction, nutritional support and health care guidance. Community care for the aged, neighborhood senior citizens centers and the Silver Haired Legislature are examples of services designed to answer the needs of this group.

As the Florida population ages, the current majority of those over 65 is nearing 80-85 years of age: the frail elderly. This group has health needs that cannot be met by community based agencies. They are no longer able to care for themselves at home, and are asking for and demanding more support services.

Adult Congregate Living Facilities (ACLF's) have mushroomed to meet this increasing need. However, the 737 licensed ACLF's in Florida have a capacity of only 31,981 beds. Only 1.9% of the over 65 population can expect to find a home in an ACLF. Those needing a greater level of care look to services provided by the Home Health Agencies in the state. In 1979-80, 82,647 patients were seen by the 143 Florida Home Health Agencies. (4.9% of the over 65 population). Finally, and perhaps more importantly for the consideration of this Committee, is the availability of nursing home beds for those elderly no longer able to survive without complete physical care.

Florida currently has 362 licensed nursing homes with a total licensed bed capacity of 39,339 beds. Only 2.3% of the over 65 population can be provided care in a nursing home in Florida. Let me clarify for you the type of care that is required by patients in nursing homes.

Level I patients are those individuals who require "extensive health care services on a daily basis, and are more than mildly incapacated, mentally and/or physically. This patient needs constant supervision to prevent deterioration and disability". FAC 10 D 29.101 (16). The minimum staffing ratios for this level of care is set currently by the state as:

> AM Shift - one (1) licensed nurse to fifty (5) patients, one (1) aide/orderly to twelve (12) patients.
> PM Shift - one (1) licensed nurse to sixty (60) patients, one (1)aide/orderly to eighteen (18) patients.
> Night Shift - one (1) licensed nurse to seventy (70) patients; one (1) aide/orderly to twenty-four (24) patients.
> FAC 10 D 29.108 (4) (b) 1.

These new standards promulgated in January 1982 reflect a 20% reduction in the minimum staffing required under previous regulations.

It is difficult for me, as a professional nurse, to contemplate how one nurse and three aids can give constant supervision to sixty patients who are severely incapacatated.

We are talking here about patients who are confused, disoriented, infantile, incontinent; patients requiring total physical care: walking, toileting, feeding, orienting.

The care that we are able to provide in nursing homes is of utmost concern to the nursing profession and it is this issue that I wish to most forceably call to your attention.

"Nursing Home" - the very name holds out the promise of qualified, dedicated professional nurses providing supportive nursing care to the residents. Nursing home is defined by Florida law to mean a facility that provides nursing services Ch 400.021 (5) F.S.

Yet I have told you how woefully inadequate are the minimum staffing requirements. And even this inadequate standard is not being met by the existing licensed nursing homes.

Prior to January 10, 1980, HRS policy was to ignore staff shortages unless they affected patient care, or there was a deficiency in patient care to which a staff shortage could relate. On January 10, 1980, HRS adopted a policy to cite all staff shortages as deficiencies and require corrective action by the facility. Since January 1981, Administrative fines totaling almost $14,000 have been assessed against more than a dozen nursing homes.

DHRS v. Apalachicola Valley Nursing Center 3 FALR 8 A - fine $500

In the matter of: Imposition of administrative fine against North Miami Nursing Facilities Inc. d/b/a North Miami Convalescent Center. 3 FALR 310 A - fine $5,000.

In the matter of: V & L Nursing Home Services Inc. d/b/a Royal Nursing Home 3 FALR 747 A - fine $1,500.

In the matter of: Health Maintenance Organizations d/b/a Convalescent Care Center 3 FALR 838 A - fine $700.

In the matter of: Imposition of an administrative fine against Health Maintenance Organizations d/b/a Bay Convalescent Center 3 FALR 891 A - fine $600.

In the matter of: Imposition of an administrative fine against Florida Land Trust No. 4368. A partnership d/b/a Woodlands Convalescent Center 3 FALR 890 A fine $800.

In the matter of: Health Maintenance Organization d/b/a Bay Convalescent Center 3 FALR 1413 A - fine $1000.

In the matter of: Pinellas Nursing Care Inc. d/b/a Crown Nursing Home 3 FALR 1419 A - fine $100.

In the matter of: Apalachicola Health Care Center, Inc d/b/a Apalachicola Health Care Center 3 FALR 1761 A - fine $1215.

DHRS v. Dade City Geriatric Center, Inc. d/b/a/ Dade City Geriatric Center 3 FALR 1634 A - fine $1300.

DHRS v. University Home Foundation Inc. d/b/a Convalescent Center of Gainesville 4 FALR 52 A - fine $500.

DHRS v. Senior Services Inc. d/b/a Crestview Nursing and Convalescent Home 4 FALR 490 A - fine $700.

Time after time nursing homes have asserted the defense of a "national nursing shortage: as grounds for their failure to provide adequate staffing. Responding to that argument Secretary Pingree has stated "Even though there is a national shortage of nurses the nursing home should not maintain a census of patients beyond that which it is staffed to handle in accordance with Department regulations". University Home Foundation supra.

Is there a national shortage of nurses? That question has been exhaustively researched nationally, and here in Florida the data suggest that an adequate number of nurses are licensed but that increasing numbers of licensed nurses choose to become inactive, unemployed or are employed in other fields.

In Florida, of the licensed 143,541 R.N.'s and L.P.N.'s, only 94,933 are currently licensed as <u>active</u> nurses. (66%). Of the total file, 21% have let their licenses lapse. Typical reasons for this include moving out of state, retirement and declining health. Inactive nurses account for 12.7% of the potential work force. Reasons frequently cited for placing a license on inactive status are working in fields other than nursing and failure to obtain the mandatory continuing education credits. The Biennial Inventory of nurses conducted by the Department of Professional Regulation revealed that sixty-three percent of nurse respondents

93-587 O—82——10

are working full time in nursing, while another 21% of LPN's and 9% of RN's are working nurse respondents. Although the percentages of total licensees vary, almost the same numbers of RN's (2,642) and LPN's (2,862) list their unemployment in nursing homes.

Whether adequate numbers of nurses are being prepared by the educational system in Florida is more debatable. In the six years 1975-1981, the number of all nursing graduates increased fron 4181 to 4428, an increase of only 5.9%. Given the phenomenal population growth rate in Florida ita appears that the nursing supply is not keeping pace.

Future supply however, is not the cirtical question. Rather we must ask "Why are so few nurses choosing to work in nursing homes?"

A study conducted by the California Hopsital Association demonstrated that 45% of Registered Nurses in California hospitals and nursing homes were hired during the preceding 12 month period -- a 45% annual turnover! The reasons why nursing homes lost RN's were identified as 1) low wages 2) domestic conditions 3) relocating 4) nature of the work with the elderly. (Emphasis added). "A Study of the Recruitment of Registered Nurses by California Hospitals and Nursing Homes" P.B. Mahan and C.H. White, 1978.

The Florida Gulf Health Systems Agency conducted a survey in 1980 designed to assess levels of job satisfaction and perveived problems within the nursing profession. The study identified the top five areas in which there is significant conflict between the value placed upon a condition for job satisfaction and the rating of that same condition under present employment conditions. For nurses working in nursing homes, the most significant problems identified were: 1) low salaries 2) poor staffing ratios 3) poor fringe benefit packages 4) limited opportunity for professional growth and 5) limited opportunity for advancement. "RN Nursing Study", FGHSA 1982.

We are aware therefore of what the problems are -- the solutions seem obvious: increase salary and improve working conditions in nursing homes, give the nurses an opportunity to provide quality care by requiring more staff and provide for professional growth by increasing the opportunities for autonomous professional decision making.

The question we are here to discuss is whether the proposed federal regulations will offer solutions for the existing problems or intensify them and create new problems.

PCMS (Patient Care Management Systems) - The concept presented of an inter-disciplinary assessment of the patients medical, physical and psychological needs is admirable. However, the definition is from our viewpoint incomplete.
§ 483.20 (c) STANDARD: COMPREHENSIVE PATIENT ASSESSMENT.
The patients needs include the need for nursing care as distinct from medical care. Nursing care goals and objectives should be an integral part of the PCMS. In a similar fashion, we believe the responsibility for seeing that an assessment is done and regularly updated is a professional one that rightfully is vested in the Director of Nursing and not a lay administrator. It is our strong belief that the Director of Nursing should be responsible for implementing the PCMS.

WAIVER OF 7 DAY REGISTERED NURSE REQUIREMENT. § 442.202
We have never supported the concept of the waiver, since nursing care is only provided by professional nurses, or those acting under the direct supervision of the registered professional nurse. Rather than editorially replace the waiver in another section we would recommend deletion.

§ 483.2 DEFINITIONS - "SUPERVISION"
The proposed definition of supervision deletes the requriement that the individual supervising or monitoring an activity be qualified to perform that function within their sphere of competence. We believe the qualifications and requriements for initial directon and periodic inspection be maintained in the proposed rule.

§ 483.11 CONDITION OF PARTICIPATION: GOVERNING BODY AND MANAGEMENT
Standard B - Staffing Patterns - The proposed deletion of this standard is nothing short of disasterous. We have previously documented the fact that nursing homes are refusing to comply with the existing staffing standards. In several cases the homes appar ntly have determined that the fine assessed was less than the cost of hiring additional staff. Nurses have identified low pay as the number one reason they leave nursing homes. By deleting the staffing requirement you are removing any incentive for nursing homes to improve pay or working conditions to attract more nurses. The lower the pay - the fewer nurses;

less nurses mean less nursing care and more horror stories of patients abused and neglected in so called "Nursing Homes".

STANDARD G -PERSONNEL POLICIES AND PROCEDURES

The deletion of this standard reinforces the problems created by the deletion of the staffing pattern reports. The problems in nursing homes center around obtaining qualified, competent help. To remove the requirement that personnel policies and procedures support sound patient care and personnel practices is unwise. Good nursing homes are not bothered by this provision; bad ones can be made better by adherence to this standard. It is not sound practice to hire unqualified, inexperienced help "off the street" and put them to work with the elderly without a period of orientation and supervision. What then, will give guidance to the uninformed and standards to the neophyte if we remove this standard?

STANDARD H - STAFF DEVELOPMENT

Once again, the deletion of this standard compounds the problems of recruitment and retention of qualified staff in nursing homes. It is short-sighted and naive to believe that total administrative discretion is appropriate in these critical areas.

STANDARD PATIENT CARE POLICY

(1) Please include nursing needs of the patient.

We do not object to the deletion of an annual review of the policies.

STANDARD COMPOSITION OF UTILIZATION REVIEW COMMITTEE

Recognizing the increasing use of alternative health care providers, most especially the geriatric nurse practitioner, we suggest that the composition of the committee be broadened to require two physicians or one physician and one nurse practitioner.

§ 483.21 CONDITION OF PARTICIPATION PHYSICIAN SERVICES

Standard: Patient Supervision By Physician - The statement that the health care of every patient must be under the supervision of a physician is in error. The role of the attending physician is to determine the medical regime to be carried out. Other professionals participate in determining the social, nursing and psychological needs of the patient. To mandate physician supervision of the total health care is to deny the rightful professional activities of others.

§ 483.22 CONDITION OF PARTICIPATION NURSING SERVICES

Standard: Administration of Drugs - The administration of medicine to the elderly, chronically ill patient in a nursing home is not a matter to be taken lightly. Because of the condition of the patient and the numerous medications these patients are receiveing, this process is more complex than drug administration in the community hospital. The potential for problems arising from drug interaction and dosage accumulation is significantly increased in nursing home patients. Therefore we believe that medications should only be administered by a physician, registered nurse or licensed practical nurse.

The removal of the process standards for drug administration and subsititution of an acceptable drug administration error rate assumes first of all that some errors are harmless. (an assumption that is not documented by any available data as it relates to chronically ill patients) and secondly that the burden of calculating the error rate will be less onerous that the burden of conforming to process standards. We believe that nothing has been gained by this proposed revision and would urge a return to process standards that have been proven valuable and effective.

The Florida Nurses Association appreciates the opportunity to present our views on the impact of the proposed regulations and would be glad to expand our comments in any area you so desire.

Senator HAWKINS. You and I talked once before about how to solve the nursing shortage and maybe this is one avenue we can go.

We appreciate your coming here today and helping us and we look for this to be an ongoing dialog.

Our final panel of witnesses consists of Dr. Irving Vinger, Mr. Fred Lane, and Mr. Arthur Harris.

Dr. Vinger, if you will proceed, please.

STATEMENTS OF DR. IRVING VINGER, ASSOCIATE PROFESSOR OF FAMILY MEDICINE, UNIVERSITY OF MIAMI SCHOOL OF MEDICINE, MIAMI, FLA.; FRED LANE, CHAIRMAN, BOARD OF NURSING HOME ADMINISTRATORS, DELAND, FLA.; AND ARTHUR HARRIS, FLORIDA HEALTH CARE ASSOCIATION ADMINISTRATOR, FLORIDA MANOR, ORLANDO, FLA.

Dr. VINGER. Thank you, Senator Hawkins.

If I may, before I begin, just request a glass of water lest I become a statistic of malnutrition and dehydration.

Senator HAWKINS. I am sorry. We should have provided that for our panelists.

Dr. VINGER. I do appreciate the invitation to come and speak with you and to enter this very significant dialog. However, I am not pleased by being here, and before anyone misconstrues that statement and sees it as being disrespectful, let me explain.

I don't think I am pleased, nor should anyone be pleased to come to hear of the many unfortunate abuses and stories of neglect and atrocities that occur to our elderly citizens in long-term care facilities today. I think our dialog is absolutely necessary, but certainly not pleasing.

Senator HAWKINS. You are right.

Dr. VINGER. Senator Hawkins, the proposed revision of medicare and medicaid Federal rules and regulations for nursing homes can have a significant positive effect on the quality of care provided in these facilities. The changes that will be made cannot be solely for the sake of change. The changes that address the present inappropriate emphasis on paper compliance over direct resident and facilities observations are long overdue. Content and process changes in the regulatory mechanism which prioritize and standardize can achieve a cost-effective guarantee of the health, safety, and welfare of the residents of nursing homes.

Given the present status of life in our nursing homes it is evident that Federal regulation is necessary, not only to protect our financial investment, but to prevent abuse, neglect, and to promote high-quality care. It is unfortunately obvious that negligence is commonplace. That both physical and mental abuse are regular occurrences and that attitudes of hopelessness and apathy for nursing home life prevail.

There is nothing homely about the majority of our 37 nursing homes in Dade County, which house 5,500 residents, approximately 50 to 60 percent of whom are medicaid recipients. Presently these homes are cold, indifferent, and sad institutions where our elderly citizens are warehoused, imprisoned in both chemical and physical restraints and deprived of human contact, stimulation, and fresh air.

Our communities are maintaining the damaging isolation of these homes and their residents as if it were contagious and be quarantined. This unfortunate reality not only robs our friends and relatives of their basic human and constitutional rights, but also robs us of a significant human resource.

As chairman of the district 11 long-term care committee in the Dade County area, which I may add is made up of 15 volunteers who investigate complaints made by residents, their relatives, friends of residents, nursing home administrators and people working in nursing homes and thus from all walks of life.

Here is a copy of an example of our pamphlet. If you have a problem or question concerning nursing home care, there are—in the State of Florida, there is one State ombudsman committee and there are 11 district ombudsman committees, one for each of the districts of HRS.

Our district is Dade and Monroe Counties.

As the chairman over the past 2 years, I have seen and continue to see these sorrowful conditions firsthand. Much of the necessary change can be accomplished by the development of a reasonable medicaid reimbursement program, which we hopefully in this State will achieve after the present legislature finishes its business, hopefully in the next week.

However, without just authoritative and supportive regulations and enforcement, we would continue the denial that has allowed our society to plunder this significant group of people. To consider regulatory revisions, which would remove the requirement for a medical director, social service director, and activities director is a blatant denial of the drastic need for the ongoing training of the staff of nursing homes.

Eighty percent of the human contact for each resident comes from the nurses aide who is untrained, paid minimum wage, and has a 60 to 70 percent turnover rate.

To suggest that no one is required to coordinate, plan, and stimulate participation in formal and informal activities is to be naive or dangerously callous. Do we not have an embarrassing excess of physician abandonment with the scarce few attending a large number of residents in our nursing homes? Do we not suffer from a decided low standard of health care for the inhabitants of our nursing homes? Rather than dismissing this need, the medical directors should be given greater responsibility for resolving these major medical care issues for nursing homes and their residents.

Denial must have been the operating attitude thus far in the provisions proposed. But it is totally irresponsible and criminal to propose that the standards of care be upheld by a review organization such as the JCAH, which has no regulatory authority and no desire to make public its findings, good or bad.

It would be much better to do away with the survey requirement for certification than to waste valuable financial resources on a farce.

Senator Hawkins, the future need not be as dim as the past. We can save dollars that are presently being wasted in surveying about 500 paper items once a year at a known time period for the purposes of certification. More frequent, unannounced, less time consuming appraisal visits, performed by regulatory agencies with en-

forcement capabilities can provide the needed feedback and consultation to the nursing homes and to the community to diminish denial, raise awareness, and invite participation.

The greatest benefit of the more frequent assessments would be to prevent the rapid deterioration of care that can occur in these facilities within as short a period as a few days.

In our community recently we experienced the gross neglect, the lack of attention to people's basic human needs of hygiene and grooming, the vermin and fly infestation and direct physical abuses of flogging and battering that can arise rapidly from the frustrations of feeling hopeless and helpless, shared by both staff and residents.

We also experienced the extremely quick improvement in care and in the outlook of staff and residents within just a few days as a result of decisive, but stern action on the part of the Department of Health and Rehabilitative Services. Let us not waste our limited financial resources nor our human resources with arbitrary deregulation, especially at a time when planned, selective and cost-effective and forceful regulations are within our easy grasp. We deserve dignified and productive long-term care facilities for ourselves and our elderly friends and relatives.

[The prepared statement of Dr. Vinger follows:]

University of Miami
Miami, Florida 33101

DEPARTMENT OF FAMILY MEDICINE
P.O. Box 016700
Location 1044A Medical Research Building (R700)
1600 N.W. 10th Avenue

March 15, 1982

Senator Paula Hawkins
Chairman
Subcommittee on Investigation and
General Oversight
1327 Dirksen Senate Office Bldg.
Washington D.C. 20510

Dear Senator Hawkins:

The proposed revision of Medicare and Medicaid Federal rules and regulations for nursing homes can have a significant positive impact on the quality of care provided in these facilities. The changes that will be made cannot be solely for the sake of change. Changes that address the present inappropriate emphasis on paper compliance over direct resident and facility observation are long overdue. Content and process changes in the regulatory mechanism which prioritize and standardize, can achieve a cost-effective guarantee of the health, safety and welfare of the residents of nursing home.

Given the present status of life in our nursing homes it is evident that Federal regulation is necessary not only to protect our financial investment but to prevent abuse and neglect and promote high quality care. The unfortunate reality is that neglect is commonplace; that both physical and mental abuse are regular occurrences; and that attitudes of hopelessness and apathy towards nursing home life prevail. There is nothing "homely" about the majority of our thirty-seven nursing homes in Dade County which house 5,500 residents approximately fifty to sixty percent of whom are medicaid recipients. Presently those homes are cold, indifferent and sad institutions where our elderly citizens are warehoused, imprisoned in both chemical and physical restraints and deprived of human contact and stimulation and fresh air. Our communities maintain the damaging isolation of these homes and their residents as if it were a contagion to be quarantined. This unfortunate reality not only robs our friends and relatives of their basic human and constitutional rights but also robs us of a significant human resource.

As the Chairman of the District XI Long Term Care Ombudsman Committee over the past two years I have seen and continue to see these sorrowful conditions first hand. Much of the necessary change can be accomplished

by the development of a reasonable Medicaid Reimbursement Program. However, without just, authoritative and supportive regulation and enforcement we would continue the denial that has allowed our society to plunder this significant group of people. To consider regulatory revisions which would remove the requirements for a Medical Director, Social Service Director and Activities Director is a blatant denial of the drastic need for the ongoing training of the staff of nursing homes. Eighty percent of the human contact for each resident comes from the Nurses' Aide, who is untrained, paid minimum wage and has a sixty to seventy percent turnover rate. To suggest that no one is required to coordinate, plan and stimulate participation in formal and informal activities is to be naive or dangerously callous. Do we not have an embarassing excess of physician abandonment with a scarce few attending a large number of residents in our nursing homes? Do we not suffer from a decided low standard of health care for the inhabitants of our nursing homes? Rather than dismissing this need, the Medical Director should be given greater responsibilities for resolving these major medical care issues of nursing homes and their residents.

Denial must have been the operating attitude thus far in the revisions proposed. But, it is totally irresponsible and criminal to propose that the standards of care be upheld by a review organization such as the J.C.A.H. which has no regulatory authority and no desire to make public its findings, good or bad. It would be much better to do away with the survey requirement for certification than to waste valuable financial resources on a farce.

Senator Hawkins, the future need not be as dim as the past. We can save dollars that are presently being wasted in surveying about 500 paper items once a year at a known time period for the purpose of Certification. More frequent, unannounced, less time consuming appraisal visits performed by regulatory agencies with enforcement capabilities can provide immediate feedback and consultation to the nursing homes and to the community to diminish denial, raise awareness and invite participation. The greatest benefit of the more frequent assessments would be to prevent the rapid deterioration of care that can occur in these facilities within as short a period as a few days. In our community recently we experienced the gross neglect, the lack of attention to the peoples' basic human needs of hygiene, grooming and body position, the vermin and fly infestations, and the direct physical abuses of flogging and battery that can arise rapidly from the frustrations of being hopeless and helpless feelings shared by both staff and residents. We also experienced the extremely quick improvement in care and in the outlook of staff and residents within just a few days as a result of decisive, just but stern action on the part of the Department of Health and Rehabilitative Services. Let us not waste our limited financial resources nor our human resources with arbitrary deregulation, especially at a time when planned, selective and cost-effective enforceable regulation is within our easy grasp. We deserve dignified and productive long term care facilities for ourselves and our elderly friends and relatives.

Sincerely,

Irving Vinger, M.D.
Associate Professor,
Department of Family Medicine
Chairman, Long Term Care
Nursing Home Ombudsman Committee

IV:am

Senator HAWKINS. Thank you, Dr. Vinger. I do believe that there is a better way. There has to be. That is why we are all here today.

There are very good nursing homes in this State. I have visited so many lovely, wonderful nursing homes. There are many very poor nursing homes and there are a great number of very indifferent ones. Most tend to be in the middle.

My concern is for those people that are living there and we do know that there has to be some changes made and that is why we are having this hearing. That is why we want all segments of those interested and involved to have some participation in this hearing.

Dr. Vinger, you are a physician and you have taken the time to be concerned and active in your community and make visits, et cetera.

Do you have any recommendations or would you be willing to help us simplify the bone matters imposed by regulators? It is the information we want, and I am sure there is a better way to get it. You are somebody that makes outside visits, I understand; is that right?

Dr. VINGER. Correct.

Senator HAWKINS. It seems to me you would be a great one to help us in simplifying that.

Dr. VINGER. Well, I think that as you mentioned, Senator Hawkins, we can rid ourselves of a great deal of burdensome paperwork. We do not have to be involved in a process which requires 500 paper items to be checked out and at the same time being unaware, not cognizant of the direct patient or resident care and the actual facility itself right around us while we are trying to deal with the procedures and the policies and all those guidelines.

There is no doubt that many of those issues can be cut in half, can be prioritized and indeed can be standardized. In our district and with the long-term care project of the Department of Health and Rehabilitative Services in Dade County, there is such a process beginning whereby the regulators themselves are suggesting more frequent unannounced visits, less time consuming, as I mentioned, and more involved with the actual residents themselves. Finding out what they look like. How they are involved in the care that they are being provided. If they are well groomed. If they are well taken care of. If they like the food. If they like their activities, and how often do they in fact get outside for fresh air.

We know from our frequent visits to many of the nursing homes and ACLF's in our community that unfortunately 50 to 60 percent of those homes do not meet minimum standards. We know that there are, of the 37 nursing homes, there are five to six nursing homes that you or anybody else sitting here would want to place a relative or friend in. The others, it would be extremely doubtful and many you would not even consider at all.

Senator HAWKINS. Do you also agree with some of the testimony we have heard here today that there is a lack of community awareness and involvement? That indeed a lot of the deficiencies we have heard about today could be avoided if the community itself were to become involved in just visiting, if nothing else?

The statistics show that so few of these people have relatives. I have just heard the thread woven through here time and time

again that the community needs to become involved in making these people feel loved, visited and aware that we care.

Dr. VINGER. Absolutely, absolutely. We in the Ombudsman Committee both at the district and State level have recognized that problem for a long time and have tried to institute a number of volunteer programs within those homes. It is not only important to have our community visit these nursing homes, but even more so what is lacking is the resident being free, to visit the community. There are many people in nursing homes who live in these nursing homes and we have got to remember that this is their home as opposed to another place. The nursing home becomes a home for that individual and it should be seen as that.

There are many nursing home residents who can leave the facility on a temporary basis, go out to the park, visit local shopping centers, go to a movie or go to a restaurant. That kind of activity should not be prevented or prohibited and yet it happens all to infrequently.

Nursing home residents get out to see their doctors, and while being a doctor I really don't consider that as being something that one would look forward to. I really think that a nursing home resident needs to get out and become and remain part of their community, which they are.

Senator HAWKINS. I find that in so many of the ones that I have visited, in my 2 or 3 years experience, of dropping in, that regulations may have caused some of the institutionalization of them. You have to follow a certain format in order to fill out these papers in order to be certified. This may have had a backlash effect of institutionalizing these people instead of treating them as real human beings.

Do you agree that there are some regulations that could be changed to humanize the institutions into a home?

Dr. VINGER. Absolutely. I think that we are dealing primarily both in terms of staff and residents and people involved in nursing home care with people who are indeed compassionate and are desirous of doing a good job and feeling satisfied by that job. I think regulations do get in the way and have gotten in the way. I think good regulations can allow and encourage staff and residents and everybody else involved to be more active, to be more involved and participate in good care as opposed to prohibiting that good care.

There are many examples of excessive paper involvement that really does prevent administrators, nurses, and everybody else involved with the care of people in these homes from actually being in contact, providing that human contact that is so absolutely necessary to provide good care. Even activity directors are spending more time working with paper. It may be a vocational therapy for them, but it certainly doesn't help the resident.

Senator HAWKINS. That is true.

Why do you think it is difficult to get physicians to attend to nursing home patients? You are really an exception in that you are a young doctor that doesn't mind making these visits and doing this out of a concern.

Why do you think it is difficult? Is it the voucher system that we have heard a lot about today—not the voucher system; that is not the right word—but the reimbursement system?

I would hate to think that is the No. 1 reason, but tell me your opinion. Is it due to the education that Dr. Pfeiffer stated was not received in medical school?

Dr. VINGER. I think that is not just solely a financial problem but in fact—physicians are really no different than the rest of the people. That may come as a shock to everybody here, but indeed they are not. They really reflect the rest of our society. The rest of our society has denied growing old, has denied dying, and has denied nursing homes as being really the place that people do both of these things.

So physicians in essence are no different than that part of society. In fact, they probably become more involved in the cocoon process because of their training. They are trained primarily in an acute care hospital setting and involved with the curative aspects of disease. So we really see the product of that training.

I think that Dr. Pfeiffer and the work he is doing needs to be expanded. I think that there needs to be a development within all our training programs, both at the medical student level, nursing student level, as well as the internship and residency levels to involve our practitioners in training and learning and working with residents of nursing homes and in adult care facilities. That is where I see the only possibility for real significant change.

If we do not do this, we will be sitting here 10 years and 20 years from now saying the same thing and yet suffering the same consequences.

Senator HAWKINS. You mentioned earlier that you had witnessed a flogging. Was that recently or in the past?

Dr. VINGER. It is unfortunately extremely recent. It was as of February 1982. This particular nursing home was an example of how a nursing home can become extremely bad very quickly.

I visited that nursing home on February 19, 1982, and if I could take a couple of moments just to describe what we went through.

Senator HAWKINS. Sure.

Dr. VINGER. First of all, as soon as we walked in the front door of the facility you were hit by this tremendous overwhelming odor of urine. The next thing that you saw was a number of residents lined up in a row staring blankly at a bare wall. These residents all lacked grooming, their hair was unkempt, the male residents were unshaven, their fingernails were dirty and hadn't been cared for. Most of them were not wearing their own clothes. There was no staff to be seen involved with any of the residents.

We walked through the facility and continued to experience the urine odor, continued to hear cries of help from residents who were lying in their beds without being attended to by the staff, without anyone coming to respond to those cries except for ourselves. We saw an 81-year-old woman who had been hit in the left eye so that her left eye was black and blue, swollen, her left cheek was swollen, her left upper lip was swollen and bleeding.

We walked through the rest of the facility and continued to see flies all over the place, roaches, and numerous examples of situations where the entire staff, although physically present, was indeed not responding at all to the care of the people in that facility or to anything that was going on in that facility.

I wish that I could say to you that that is the only example of such terrible conditions that I have witnessed in the 2 years that I have been chairman of this committee, but it isn't. We continue to get complaints, requests for help from people who have been neglected.

We have another example of a 75-year-old woman who had been in a nursing home for 2 years who had been doing well up until recently and then developed swelling and slight ulceration on her right leg. That swelling and ulceration was neglected both by the physician in the nursing home and nurses caring for that individual to the point that, both in terms of the documentation of the suffering that that individual was involved in, as well as the followup care, here is an individual who on 1 day had a swelling and ulceration, that was followed for that for about a week, and documented in the records. Then the recordkeeping for that incident stopped both in the nurse's notes as well as the physician's notes. There was a note stating that she had an appointment for a plastic surgery clinic at a local hospital, which would take place 10 days hence. Here was somebody who the nurse's notes identified as having gangrene of her right leg. The day she came for this "appointment" in a clinic of a local hospital, she was immediately admitted and had an amputation above the knee of that extremity.

We have had another recent example of someone who while in physical restraints somehow got to a match or a cigarette lighter and burnt themself and died as a result of those burns within a few hours.

We have another example of a man, who had been depressed and had a terminal problem, walking out of one of our local nursing homes to "commit suicide by drowning in the canal behind the home."

There are just too many of these incidents for us to at any time presently think about limiting enforcement, limiting standards, or deregulating in the sense that I saw in the proposed revisions.

I appreciate—and this is not said in disrespect—but I appreciate the recent period of lucidity on the part of Secretary Schweiker and the administration in making changes in their proposed revisions. I just hope that it is consistent and constant and does not change because if it does, we are very much in danger of continuing the kinds of things that I have described here today.

Senator HAWKINS. Thank you, Dr. Vinger.

I hope they will improve.

I think we noted from your testimony and others that there is something to give on each side and that we can start with what we have to improve conditions.

Dr. VINGER. There is one other point.

There can be improvement, I think, indeed, and I want to perhaps end on a very positive note. Improvement is just within our grasp. The State of Florida in this recent legislature has moved very close to a new medicaid reimbursement program, which will be revolutionary. The State of Florida is very close to passing a nursing aide training bill, which will provide education for those people who, as I mentioned, spend 80 percent of their time in contact with the residents and with whom the residents spend most of their time.

We look forward to—and many of these bills have been an outcome of cooperation between the nursing home industry, the HRS, and the Ombudsman Committee and many other consumer groups. So the dialog has started. The future is bright as long as we make sure that we don't curtail our vigilance, as you have mentioned many times, too soon.

Senator HAWKINS. You have said a lot of things for us to think about, but one of the statements that hit me, was the example of a good home gone bad. I have visited those also and there is a valley and a peak, et cetera. I think that it points as much to the community as to the professionals.

I know so many people who have placed their parents or their relatives in a very good nursing home and for economic or other reasons, are not able to visit often. They don't often even live in Florida. Florida has a wonderful climate and they send their loved ones here because of the climate. Then they can't visit often. Just because it was good when they got there doesn't mean it is going to remain good, especially where that person who has a loved one or a relative in the home is not able to provide constant vigilance.

So I think it is not only on the nursing home operator or the group that oversees the consumer aspect, as you, but the individual. Everybody there has someone that placed them there.

I think the dialog has started and the vigilance should be on all parties. Let's make it a better place. I love to say the future is ours because we will soon be there. I think your eyewitness accounts really point out the need for our constant vigilance and attention to the situation and continuing dialog among all parties involved.

This is going to be a growing problem, not one that is on the downside. It is on the up side, and we appreciate your coming today.

Mr. Fred Lane will be our next witness.

He is chairman of the board of Nursing Home Administrators and he is from Deland, not Orlando.

I know Mr. Lane and I would like to ask you a few questions.

Mr. LANE. I might interrupt for just 2 minutes——

Senator HAWKINS. Sure.

Mr. LANE. I came to Florida with my parents in 1938 and my mother and father still live here. My father is a retired Baptist minister, still preaching in the community. They are involved in caring for or being with two nursing home patients at the present time and they are both here today. Dad preaches every Sunday.

I am sorry for the interruption, but that was just a personal point of privilege——

Senator HAWKINS. That is a great example for all of us. I think it is a lesson for all of us. I think the great rush Americans had to retire was maybe premature. I am so proud of parents like that and also children who have kept them in the mainstream.

Mr. Lane, do you favor the proposal by the Health Care Finance Administration that nursing homes should be certified by the JCAH, the Joint Commission for Accreditation of Hospitals?

Mr. LANE. I think it is well worthy of consideration. The thing that concerns me about just the arbitrary dismissal of consideration of this without the exception of individuals who proposed it as indicated by previous testimony, have either been directly involved

in Government itself or indirectly involved and very influenced by Government. I have looked at the proposal. I have studied the potential deem status, and I think it is one alternative that really should be considered. It may well be denied, but this is among other things that have been proposed by the Secretary that ought to be considered because we have heard, as you say, a thread throughout this testimony today of the necessity for revision, this necessity for less paperwork and these kinds of things.

To arbitrarily and without all sides being well represented throw out something that might be of value would be a serious error.

Senator HAWKINS. That is why we are having this hearing.

Mr. LANE. Exactly.

Senator HAWKINS. I don't know that they are being thrown out.

Mr. LANE. I would encourage that the potential for deem status be one of the alternatives that might be available. For example, you have raised the question several times today about one facet, the observation of surveys on alternate years or every third year in a facility. Some facilities have a very fine reputation and record in their survey process. It is possible that this might be one of the alternatives, for individual facilities that do have a very fine reputation for experience in the State survey process to have alternate years of joint commission review.

Senator HAWKINS. Don't you think that that would cause what Dr. Vinger just said, a good home going bad faster if they knew they were only going to be inspected every other year?

Mr. LANE. I do not, because there are continual inspections. We have some 30 to 40 organizations to whom we are directly or indirectly responsible.

Senator HAWKINS. I know there are a lot and I think that is one of the ways we can work together and get fewer, but better——

Mr. LANE. I think they should be brought more in focus. I think it is one of the areas that has not yet been truly addressed in any of the regulatory recommendations.

Senator HAWKINS. I noticed that.

Mr. LANE. I think that is one of the serious errors that should be addressed.

Senator HAWKINS. I have never seen a good school teacher that minded being tested or a good nursing home that it mattered at all if the inspector came. Just don't come right in the middle of doing something that is very important for the purpose of a ceremonial visit.

They should be meaningful and they should not be repetitious.

I think we are on the threshold of taking a big step forward here in Florida.

Mr. LANE. Very much so.

One of the areas, for example, that could be well considered for occasional review, and the good doctor has referred to, is policies and procedures. It is very interesting to sit in the survey process and spend a great deal of time with one of the surveyors who has read my policy and procedure manual two, three, and four times and perhaps knows it almost as well as I do. He knows that what is required is there.

Another area, for example, is fire safety.

A facility either qualifies and meets the regulations in fire safety or it doesn't. The question is one of maintenance. This would be a very reasonable quick check. These are the kinds of things that very urgently need to be addressed.

One of the areas that I am very, very pleased with and was not when it first came out, was the approach to patient care plans. We thought we had a very good approach to patient care in our facility. I saw this as one potential paperwork involvement that was not necessary; however, we were forced to do it. In that process, I asked those of our people that were involved in it to review what we had done in the past and very carefully consider what we were doing and then come back and look at what the new care plan program would be.

I was very surprised. Their evaluation of the patient care plan where there was a multidisciplinary approach of utilization of efforts to provide the full care for that patient was most satisfactory, both for the patient and for the employee, because they began to see, for the first time, some real progress and documented progress in the patient care.

There have to be others that will speak to that area.

I had an opportunity last Friday, Senator, and I have not had a chance to check with your staff about this, but we have spoken several times throughout the day about education. Last Friday I met with the representatives from the Board of Regents, University System, State of Florida, preparing a regional master plan for an effort to meet the needs of the State.

One of the areas that we are vitally concerned with, particularly in licensing of nursing home administrators, is the educational background of administrators. The problem at the present time is the low educational minimum entry into a licensed administrative position. This is, to my knowledge, about the only administrative position in the United States that is licensed, which is a startling fact.

The minimum entry level in the State of Florida at the present time is 18 years of age, a high school graduate, and the ability to have 1 year in an administrative program and pass a national exam. So a person 19 years of age with the ability to pass the test can become a licensed nursing home administrator.

We are proposing in several areas a step approach into a baccaleaurate degree. A minimum of 2-year degree for x number of years, 2 to 3 years, and then a full baccaleaurate degree. We are having difficulty at the present time determining exactly what that baccaleaurate degree should be, because our experience has shown us that individuals from various backgrounds become excellent administrators. It does not have to be experience or baccaleaurate work in any specific field.

The other potential that is intriguing to the members of my board at the present time is that after a period of years, say 5 years, we are considering the possibility of asking a person who has been licensed and practicing steadily in the State of Florida to take a competency testing program which has been prepared by the American College of Nursing Home Administrators.

One of the better things that I have seen anywhere around is one of the few things that literally tests competence.

Senator HAWKINS. I appreciate that.

Do you also agree that there needs to be a higher level of training for the nurses aides that actually do 80 percent of the work with the residents?

Mr. LANE. Yes. I have been involved a great deal with this on a statewide basis and a local basis.

In Volusia County where I reside, we were able to get our local community college to institute a 180-hour program and the nursing homes in our area, the other thing in their power to find orderlies that have been through the first course, which is 180 hours. I think it has been expanded to 240 hours now.

It is strictly a volunteer program on——

Senator HAWKINS. Just in your county?

Mr. LANE. In our area.

There are other places in the State that have this type of aide training in a community college system. The problem, however, is in the efforts in trying to develop this in the community college system. The frustrating part from my standpoint is that every community college wants to redevelop wheels. They want to have their own complete, unified, totally controlled, self-contained system.

For those of us who are cost conscious and anxious to get well-trained personnel, it is a frustrating experience.

Senator HAWKINS. Do you know how many schools have that program?

Mr. LANE. I think there are about—I am really not positive, but I believe there are about four or five at the present time that have that in the State.

Senator HAWKINS. Do you think there is a nursing shortage, as far as administrators are concerned?

Mr. LANE. Yes, there is, according to the area of the State. In my particular area, I have not experienced the severity of nursing shortages that others report. However, I am convinced from previous testimony that one of the problems is in wages.

In our area, we have made efforts, specific, concentrated efforts to upgrade the wages.

Senator HAWKINS. You heard testimony about the nurses and it is really criminal, wouldn't you think——

Mr. LANE. Well, Senator, this comes back to a problem that I think frankly both State and Federal governments have been hypocritical about. In my opinion, one of the cruelest hoaxes perpetrated on the elderly is the medicare program that tells people you are qualified for 120 days in a nursing home care. It is not true except in very rare instances. People believe they are going to have this much coverage and then when they come to the point they are going to need the care, they are devastated from a psychological standpoint as well as a monetary standpoint. They are told when they are medically indigent and financially indigent that they will qualify for medicaid coverage.

The State and Federal Governments say, we will meet the cost of your care. Then the regulations are proposed and the cost of those regulations exceeds what the State and Federal governments are willing to pay. Almost without exception, the facility administrators that get in severe trouble and come before our board for sanc-

tions of various kinds, in direct proportion, the percentage of medicaid involvement.

The facilities that are heavy medicaid do not have the money to meet the standards required of them.

Senator HAWKINS. That is something to think about when we talk about cutting that amount of money that we now have.

Mr. LANE. That is what the doctor was referring to. We have tried—and Mr. Harris, I am sure, will speak of this—we have tried for years to get direct State legislatures a reasonable reimbursement system that would provide an incentive of profit.

Senator HAWKINS. I hope——

Mr. LANE. We trust that those in the State and Federal governments will still understand that profit is an honorable way of life.

Senator HAWKINS. It made America great, and I hope that we will now use that training in the last phase of our lives, which have made some, almost an entire generation, rather bitter. I don't think it is incurable. I think that working together like you are doing has brought us to the threshold of getting some State cooperation. I am well aware of your role and that of the Florida Association of Nursing Home Administrators. It is so important that we have effective administration.

I do appreciate, and I know that other people also appreciate your contribution here to this hearing and your dedication to upgrading the role of administrators, which is indeed one of the weak areas we have had to look at.

We look forward to working with you. Thank you for being here today.

Mr. Harris, I understand you have quite a lengthy statement and we would like to incorporate it into the record. As I have said, I am just conducting this hearing as chairman of my subcommittee, but the other members of the full committee will wish to read it prior to going into any markup of any proposed regulations or prior to any action that we may take.

If you could summarize what you have, I have a few questions for you.

Mr. HARRIS. I probably will not say much about what is on the report, but I would like to make a couple of statements concerning some of the problems that have surfaced today.

One of the things the doctor was talking about is the rapid change seen in nursing homes. Fred Lane and I have been involved in this for many years. It was recommended to the State for the past 4 years that a group of industry, office of licensure, and audit section have a focal point in Tallahassee in H.R. 5 so that when one of the groups see a problem coming in a nursing home they get that group together to try and solve that problem. Had they done this with the nursing homes in Miami that the doctor is talking about we all might have helped, but by the time we found out about it, they were in total bankruptcy. Had somebody pointed this out ahead of time and instead of everybody going their own little way, we would have been able to help. We have been able to help others around the State this way before they got into this position.

I think this is something we are going to have to move to.

The other thing is we have had many speakers that have been very eloquent about the problems and sometimes they don't really

understand what they are speaking about. We are speaking about 14 million patient days. We are speaking about 275 million patient encounters each year and, you or I or someone else can make a mistake, but it is really magnified and it is important that we not make these mistakes. I want you to understand that these are human beings. Most of them are very well trained and I am tired of these people insulting these nurses aides that really give their time and really do work hard to take care of these people, and it is a pretty thankless job——

Senator HAWKINS. And poorly paid.

Mr. HARRIS. Yes.

Senator HAWKINS. I want to say that nurses aides have to be dedicated. I have a good friend that works at Sunland. An individual has to be a certain kind of human being to want to report there every day to work with loving care. My friend makes minimum wage, which is just beyond the imagination in this profit-seeking generation. She is one of the young people who is truly dedicated. I did want to add that to the record; that these nurses aides have to be dedicated to make those wages and do the kind of hard physical work that they do.

Mr. HARRIS. On the other hand, they take a lot of abuse and a lot of this is not brought out. I have seen my nurses aides kicked in the stomach, kicked in the face, scratched so deep that the blood just runs off their face. You forget about all of those hundreds and hundreds of nurses aides that are treated just as badly as the patients. This is not done intentionally by the patients, I understand that, but it is a terrible thing that some of them have to go through. So, those are the problems.

Some of the problems also get to—and you have talked about this, about the people that really do not visit a patient in a nursing home. It does not only happen to families, but friends and everybody else. You know, while they are in a hospital—and I have been guilty of this myself, my father-in-law was in the hospital and I went to see him every day. Nobody in the hospital shaved him; I shaved him. My wife went and fed him his meals. I fed him supper and she fed him breakfast and lunch. We saw that he had clean clothes. If he needed a change, we would tell one of the nurses. We were there and we did all of this. People will do this while they are in acute care hospitals, but the next day they move into a nursing home and they do not visit any more. If they do visit, then they want every one of those things done for them by the time they get there and it is for a third less money than they were paying in the hospital.

So, if there is some way we can get somebody, again, to do the same thing for the patient they do in the hospital, then I think we are okay. The problem is there are people who have spoken so eloquently about their concerns at this hearing, but I wish they had been that eloquent all year long.

Senator McKnight made a statement on television about 2 weeks ago that he had heard many, many people speak regarding law enforcement, but heard nobody talk to him about the care of the elderly and nursing homes, or community care, or any of those other programs. That is a crime. Everybody can run all over the State to come here and bring you these problems, but while our legislature

was in session there were only two or three groups in the whole State that were doing anything about it. One of them was the State Ombudsman Committee. One of them was our association and a couple others, but all of these people that are doing all this hollering now, where have they been for years—we had enough money last year in the budget to implement the Gainesville plan, but the State did not implement the Gainesville plan, because the legislature said it was not the intent because the people did not ask for it. It was there. It was in budget. It was taken out and used to take care of the Cubans and Haitians, but the money was there last year. Now, if it is done this year, and if the Legislature agrees to it—it will not be for about 12 months because they are not talking about implementing until April 1983. So, we do need to move on that.

I am sorry about getting a little intense, but I do get a little bit intense.

Senator HAWKINS. You have a right. Everybody here has been rather intense. I like the fact that we feel keenly about why we are here.

Mr. HARRIS. We finally did sue the State and while Fred was president of the association a year after I was president of the association, we tried to work with them. We did sue the State and we did get a lot of concessions; however, it might be interesting to note in December 1980, even Health and Human Services ruled that Florida's plan was an illegal plan and an improper plan. We are still sitting today without a proper plan to pay for the care of the patients in Florida.

Senator HAWKINS. In your statement you objected to certain paperwork and documentation requirements, stating that they substantially increase the costs with little or no improvement in patient care. Yet we all know that patient charts and other records give the inspector something to look at. Exactly what do you——

Mr. HARRIS. I am not at all talking about the documentation on the patient's chart as far as the care and treatment from the doctors orders and things like that. I am talking about the many times we have to document that somebody does not need something. You know, we are talking about you have to do an assessment of a patient and that is fine, but then a reassessment has to be done and everything else to see that that patient does not still need something.

Now, there are enough people involved with these people every day that after the initial assessment is done, unless there is a change in that patient's condition, a drastic change, you should not have to do an additional assessment just to prove there is still nothing that needs to be done as far as that particular level of care goes.

For instance, under some of the plans for patient care, and I have no objection about interdisciplinary input, and we do have interdisciplinary input in our facility, but it says in there that the activity director has to consult with the nurse on every patient. Well, if that nurse has 35 patients and she has to consult 35 times with the activity director, 35 times with the food services manager, 35 times with some social person and 35 times with the doctor, she is not going to have time to take care of the patients. So, someplace

along the line, we have to come up with something that says this is the assessment, this is what we are going to do, and things like that.

Another thing that we have that I have no problem with in my facility is we have a group of patients that have formed their own organization and the activity director has asked them about new activities and things like this. We do implement these. The regulation says that the activity director has to sit down with every patient and talk with them about their activity plan. Now, that is a ridiculous thing. We have an activity plan that is based on a study of all the patients in the facility and those patients—I think it would be better to direct our energies to seeing that they take advantage of what is there.

The doctor was talking about visits outside the facility and we do have visits outside the facility, but some of these people do not want to go outside. They do not want to be outside. We have a cookout every week that we get about 150 of our 420 patients to come to. Many of them say, "I never went on a picnic in all my life, and I am damned sure not going to start now when I am 90 years old."

And I understand that. And you have to go along with it.

There are other State regulations that require certain items to be taught. Inservice education, I have no problem with. We have always done that. Now we have to write plans for each one of those things. We have to update that plan annually, and we have to have some committee meeting and things like this for something that we have been doing. So, I index medical records by several diagnoses. This was started by the Federal Government in 1974, I think. They said this was so they could retrieve the information. Well, you know, we have had 7,000 patients and nobody has ever asked me to retrieve a cockeyed thing, yet we still go on cross indexing and setting up card files and everything for these patients and nobody has ever asked me for anything. We do it, you know, but nobody has ever asked for anything.

These are some of the paperwork items that if people would look at they would see what I am talking about, and we would get better direct care of the patient.

Senator HAWKINS. That is what we are talking about, getting better care for the patient and still having the access to this information.

Do you favor an inspection process that would allow inspectors to focus their attention on homes with a history of violations?

Mr. HARRIS. The oversight committee in our House, Florida House of Representatives, in the past year did a study on inspections in the State. They did recommend some consideration be given on a full inspection for those facilities having good inspection profiles every third year, but on the off years to do an inspection on patient care. I think this would be a very good way. This would stop the problem the doctor was talking about.

I have never objected to inspections. It does not bother me that much. To comply with 700 checkoff items in Federal regulations and now we have another 485 in the State regulations, and never be able to be wrong in any one of these 1,100 or 1,200 items is asking pretty much of the facility, but I do not oppose those. I do

think that we would be better if they would go in and just take a look at the patient care and look at the results and every third year, if the facility does have a good patient profile, to check all the paperwork and everything.

[The prepared statement of Mr. Harris follows:]

OPENING STATEMENT OF ARTHUR HARRIS,
ADMINISTRATOR, FLORIDA MANOR NURSING HOME

My name is Arthur Harris. For the past 16 years I have been the administrator of Florida Manor, a 420-bed nursing home owned and operated by the Catholic Diocese of Orlando. Since 1969, I have been the liaison between the Florida Health Care Association (FHCA) - an industry association consisting of approximately 250 of the 358 nursing homes in Florida - and the Florida Department of Health and Rehabilitative Services, the state agency that is responsible for the administration of the Florida Medicaid program. Since 1970, I have been a member of the Medicaid Advisory Committee to the State of Florida. Also, I am a past president of the Florida Health Care Association.

On behalf of the many health care professionals who operate the nursing homes in the State of Florida and the patients they serve, I thank you for the opportunity to testify today and appreciate your interest in the care and welfare of our nursing home patients.

I. QUALITY OF CARE

In your communication to me, you asked that one of the topics I discuss be the quality of care rendered by Florida nursing homes.

I believe that the quality of care in most nursing homes in Florida ranges from adequate to very good. This evaluation includes all facilities - from those that render only basic care to those that offer every type of service. In assessing the quality of care in any health care facility, you must consider the conditions and circumstances under which the services are delivered.

Last year, Florida nursing homes rendered 14 million days of patient care. On each of these days, at least one nurse and one aide on each shift had a minimum of 3 service encounters with each patient - a total of 252 million encounters. Besides nurses and aides, there are many other service personnel who have contact with the patients -- housekeepers, dietary staff, office workers and

activity and maintenance personnel. All of these encounters total well over 275 million per year. That is 275 million opportunities for some nursing home staff member to make an error, or to do some act that would anger a patient, family member or friend.

For the most part, the patients that nursing homes serve are people no one else can care for or really wants to care for. Most suffer from multiple diagnoses. Some are belligerent. Many are confused. Many are incontinent. Many have paralysis, fractures and decubitus ulcers (most of which are acquired before the patient is admitted to the nursing home). Some patients have terminal cancer and other dread diseases.

Nursing homes do not serve only our elderly population. We exist to serve anyone who has need of institutional long-term health care. For example, an increasing percentage of our patients are young people. Some of these young people suffer from severe brain damage or spinal cord injuries. Some have suffered from debilitating or terminal diseases. Care of these patients is often difficult and emotionally draining. Some are comatose. Others are paraplegic or quadraplegic. All require an extra measure of care and concern.

One complaint often heard about nursing homes is that their staff is inadequate. Very often, such complaints are the result of unrealistic expectations on the part of the patient's family. For some reason, when a patient is admitted to a nursing home, family and friends of the patient expect much more service than the patient received in the hospital, yet overlook the fact that nursing homes receive only about 1/3 of the amount reimbursed a hospital for a day's care. In the hospital, the family is willing to assist the patient with his or her meals, with bathing, and other needs. However, when the patient is transferred to the nursing home, many families and friends terminate their assistance, but expect that all personal services should be performed for the patient and completed before 10:00 a.m. Such expectations are unrealistic given the nature of the patients, the funds available

for staffing, and the other obligations of the nursing personnel.

Nursing home food is another area of complaint. When the patient was at home, failure to follow an appropriate diet may have been the very reason why the patient's health deteriorated and he needed professional care. In the nursing home, the patient will be subjected to an appropriate diet as prescribed by his physician. Perhaps his sugar, salt or fat intake will be restricted. Many patients resent this infringement on their personal choice and complain about the blandness of their diet. Simply put, it is almost impossible to make foods on a restricted diet taste good to a patient used to eating an unlimited but unhealthy diet.

These are but two examples of the types of complaints made against nursing homes that are, in my judgment, unjustified. That is not to say that valid complaints do not exist - they do, and they should be heard and the source of the complaints corrected. My point is that any perceived deficiencies in the service that nursing homes give must be considered and evaluated with an understanding of all of the conditions under which that service is rendered.

We recognize that problems do exist in our industry. For several years, FHCA and its member homes have worked with the state agencies in attempting to upgrade the few facilities that do not give good service. Our attempts have often succeeded; however, on occasion, have failed. The failures were due, in large part, to a very inadequate Medicaid reimbursement program which has forced some facilities to close and others to sell to large chain organizations that have better funding available. We are not proud of our failures, but do realize that problems exist in any industry. Ours, unfortunately, is an industry that receives wide-reaching publicity when it fails, but little when it succeeds.

Very often the nursing home staff members believe that theirs is an impossible task, and that belief is not altogether unjustified. For example, if we place a patient in a safety vest to keep him from falling out of his wheelchair, some consider us

cruel. If we do not use a safety vest and the patient falls, some accuse us of not protecting our patient. If we take a firm stand with our patients and require them to do those things for themselves that they are able to do, as the regulations require, some accuse us of not providing adequate services.

When people visit our facilities, they expect the facilities to be in perfect order - immaculately clean from top to bottom with every patient freshly bathed, dressed and ready to go. Once again, such expectations are unrealistic. Memories of families and friends are sometimes very short. People forget the problems they themselves had with the patient at home - problems which may have caused the patient's admission to the facility in the first place. They overlook the fact that the single problem they had at home is multiplied many times over for the staff in the nursing home. Those who care for these patients do a difficult job under difficult circumstances.

There are some who act as though nursing home employees are supposed to be a breed apart. They are not supposed to have emotions. They are never supposed to feel out of sorts, get angry, or raise their voices, not even when kicked or scratched by a confused patient during attempts to bathe, dress or do some other service for the patient. They are supposed to remain passive against verbal assaults by a family member for the failure to easily perform some task for the patient - often the same task that the family member found impossible to perform at home.

In my judgment, when all facts and circumstances are considered, the quality of care in Florida long-term care facilities is very good. In those instances where problems exist, we recognize and respond to a duty to help rectify the situation.

II. REIMBURSEMENT AND THE "GAINESVILLE PLAN"

Notwithstanding my opinion that the general level of care is very good, I recognize that there is a great deal of room for improvement. However, major progress in this area simply cannot be made without a more equitable reimbursement level for the care

given to the Medicaid patient. In fact, the single most important item that would lead to improved patient care in nursing homes throughout the State of Florida would be the implementation of the new reimbursement plan - the Gainesville Plan - as it is presently written. This plan is the result of many months of intense work and negotiations by officers of the Florida Department of Health and Rehabilitative Services and members of the nursing home industry. Unlike the plan which is presently in use, the Gainesville Plan contains incentives for nursing homes to improve patient care and contain costs. It is a plan approved by the Florida Department of Health and Rehabilitative Services, the nursing home industry, and the Florida Long-Term Care Ombudsman Committee. If this plan is funded by the Florida Legislature, as we hope it will be, it will replace a system of Medicaid reimbursement that does not now, and never has, adequately funded the cost of caring for Medicaid nursing home patients. If properly funded, the Gainesville Plan would pay for more adequate staffing, better staff education, expanded activities, greater selections of food, and other things that would permit the nursing homes in the State to provide the type of care that the patient, the patient's family, and the public have the right to expect and, indeed, to demand. An adequate level of funding provided in conjunction with a thorough but fair system of audits and inspections can do a great deal to improve the efficiency of the health care delivery system as it serves its patients.

At this point, we are very disappointed in the way the Florida Legislature is proposing the funding of this plan. The House, assuming that a one cent increase in the sales tax will be passed, has included only enough in its appropriation bill to begin funding the Gainesville Plan on April 1, 1983. The Senate, at present not anticipating a tax increase, has not included any funding for this plan in its bill.

There has been a great deal of discussion in the media to the effect that the elderly and infirm portion of the population,

not only in Florida but throughout the country, are the forgotten members of society. We hope that the voice of the infirm and the elderly will be heard in Tallahassee during discussions on funding for the Gainesville Plan. However, we have grave concerns in this area. We are not at all certain that the people of Florida are genuinely interested in the type of care provided to Medicaid nursing home patients. Recently in a television interview in Tallahassee, Senator Robert McKnight said that he had heard from many people about the need for extra money for law enforcement and schools, but from no one about the need for extra money to provide for the care of the elderly.

We advocate this year, as we have for years, that all aspects of health care be properly funded, including such programs as community care for the elderly, day care, adult congregate living care and nursing home care, not only for the infirm elderly, but the infirm young as well. If these programs are properly funded, the elderly and infirm could be cared for in the best setting appropriate to their needs, thereby ensuring the most effective utilization of scarce tax resources.

III. REGULATIONS REGARDING NURSING HOMES

On the subject of regulations regarding nursing homes, I would like to begin by imploring lawmakers and regulation draftsmen to do a cost effective analysis prior to proposing new regulations for nursing homes. That is, prior to proposing a new regulation, analyze that regulation to determine whether compliance will result in improved patient care and whether the cost of compliance will result in a corresponding improvement in the level of patient care. This is particularly important in these days of scarce tax resources for funding medical programs.

The cost to the taxpayer and industry was blatantly ignored just recently by the State of Florida when the Department of Health and Rehabilitative Services revised Chapter 10D-29, Florida Administrative Code, the regulations which govern nursing homes. Despite the fact that uncontradicted testimony was presented to the

State that the implementation of these rules would cost the industry many millions of dollars, HRS chose to ignore the evidence and adopt many useless, expensive and time-consuming provisions. There are many changes in 10D-29 and we do not object to all of them, but we do strongly object to extra paperwork and extra documentation which bears no relationship to improved patient care.

We realize that some documentation is necessary, but we believe the demands of these new regulations are ridiculous. Some examples that could be eliminated are:

1. Regulations requiring an education plan for the facility and a separate one for each department. A simple list of the items to be taught could be prepared for each department. This would eliminate the preparation of seven plans.
2. Regulations requiring that the nursing home mail certain forms to patients' physicians notifying them in advance of the recommended schedule for their visits. The regulations also require that a second form be mailed to the physician should he miss a visit. Finally, the nursing home must attempt to notify the patient's family of an impending physician's visit. In our judgment, physicians are professionals and the nursing home should not be required to police them. That chore properly belongs to other physicians. Simply requiring the nursing home to give each doctor a copy of the regulations setting forth his obligations would put him on notice and would save time and expense to the nursing home.
3. Regulations requiring that there be a written plan to secure relief personnel for each department and document that said plan is being utilized. By necessity, a facility must have adequate staffing and the requirement of a written plan will not assure that relief personnel are available.

Other blatant examples of the extra paperwork which will increase costs with little or no improvement in patient care are:

1. All facilities must have a written agreement with a hospital.
2. All facilities must maintain an admission and discharge register.
3. All facilities must maintain written agreements with all third party providers and consultants.
4. Each employee must be evaluated at the end of three (3) months and annually. Previously, facilities were only required to evaluate employees annual In a facility with numerous employees, this could t to many additional forms.
5. Each facility must have an education plan for all employees in the facility which must be revised and reviewed at least annually or as necessary and documentation that this has been done must be maintained.

I could go on listing the useless paperwork. For expediency, I have set out other examples of extra paperwork which will substantially increase costs with little or no improvement in patient care in Appendix One, attached to my written opening statement.

In concluding my remarks regarding the new Florida regulations, I must point out that the patient care planning section the way it is presently written would not only require extra paperwork, but would also require additional staff - obviously increasing costs - or would take staff time away from direct patient care. Several months ago we recommended an alternative to the patient care planning section. Unfortunately our efforts were, for the most part, ignored.

IV. PROPOSED REVISION OF FEDERAL REGULATIONS

At this point, I note with approval what appears to be an effort by the Department of Health and Human Services to ease the regulatory burden on nursing homes by eliminating unnecessary regulations. We in the industry are concerned as to what progress, if

any, has been made in this effort on the part of HHS. I have a draft proposal of "Conditions of Participation for Skilled Nursing Facilities" dated December 17, 1981, which was kindly furnished to me by Mrs. Terri Parker of your staff. I have been given to understand that this may not be the final draft and that there may be another version in circulation. Of course, my comments directed at the "Conditions of Participation" are based upon the draft which I have. I would urge, however, that HHS move forward and publish a final draft so that the issue can be officially placed on the public forum for comment and hearing. Interestingly, in comparing the proposed revision of the federal regulations with the revised Florida regulations, we have found that Florida added to its regulations everything that the federal government apparently cut out of its regulations. Obviously, the federal government seeks to ease the financial burden on the health care industry while Florida seeks to exacerbate it.

We have reviewed the proposed revisions and for the most part we find them a welcome change. However, there are some areas of concern. First, we are concerned that federal matching dollars may not be available to pay for more than the minimum care that the regulations require. Florida regulations require much more. Second, we are concerned about the lack of funding for the survey agency. We need funds to pay for qualified people to survey our facilities. Third, some of the proposed revisions can be very costly and unworkable because they conflict with state regulations, or are just impossible to comply with because the perceived problem is something over which the nursing home has no control.

The following is a list of some problem areas in the draft which has been provided to me:

Section 483.11 with regard to Patient Care Policies requires, in subsection (e)(1)(iii), that if a facility meets the need of patients through arrangements, "those arrangements must be with providers or suppliers approved under the Medicare or Medicaid programs." Florida regulations require arrangements with outside

resources that may not have any method of approval under the Medicaid or Medicare program - such as social services agencies, audiological services, etc.

Subsection (f)(5)(ii), regarding patients' rights, states that "transfer or discharge policy prohibits discharge because of conversion of a patient from private pay status to Medicaid eligibility due to exhaustion of financial resources or from Medicare or Medicaid." This rule does not state that it only applies to facilities that participate in Title XVIII and XIX. It implies that the facility must keep the patient regardless of his source of payment.

Subsection (7)(ii), with regard to patients' funds, states that the facility "[a]void[s] the co-mingling of patients' funds with facility funds or the funds of one patient with those of another person." Past interpretations by surveyors considered funds co-mingled only if the patients' funds were in the same bank account as the facility's operating funds. Under the new regulation, the facility would have one of two choices: (1) open a separate bank account for each patient, or (2) keep each patient's funds in a separate envelope at the facility. The regulations should permit one bank account for the patients' funds separate from the facility's operating funds, with separate accounting for each patient.

Section 483.20, regarding patient care management, requires an extensive documented patient care plan. This is a totally new section that can be very costly. The regulation sets out a very complex procedure that does little for the patient that is not now being done, but takes the valuable time of the staff that should be devoted to the actual care of the patient.

Six years ago, 200 nursing homes across the United States participated in a pilot program. The result of this program was that such extensive documentation was too time consuming and too costly for the benefits derived from it. In January, 1980, this program surfaced again. The cost projected by HHS, even though very high, was disputed as being too low by the General Accounting Department. I point out that although the wording of the regula-

tion has changed somewhat from the original proposal, all the elements are the same.

As you know, patient care planning is already required and the surveyors have access to the medical records to review the progress. Another group of assessments is not needed. In order to comply with this one regulation, most facilities would be required to add staff or cut other services. Most of us have kept costs as low as possible. This regulation would require more time by nurses, activities directors, and dietary supervisors.

Consider for instance the section that requires that team members exchange information about the patient's care and ensure coordination of their related activities and document in writing all such information in the patient's medical record. An activities director in a 120-bed facility would have little time remaining in which to direct actual programs. She would spend most of her time consulting and documenting. Consider also the floor nurse with 40 patients who would have to consult with all disciplines on every patient. She would not have time remaining in which to provide actual nursing services to the patients.

An example of a federal regulation which conflicts with state regulations can be found at section 483.21, which states that each patient, or his representative, has a right to designate an attending physician in accordance with the policies of the facility. However, Florida regulations allow a patient to use the physician of his choice and do not allow the facility to establish its own policies. Compliance with this federal regulation by the facility - instituting facility policies for physicians - would cause the facility to violate the state regulation.

Section 483.21(a)(2)(ii) requires that within 48 hours of a patient's admission the facility must have a summary of prior treatment. The physician in most cases has 30 days to dictate a discharge summary at the hospital. To require the nursing homes to have this in 48 hours places a requirement on us over which we have no control. In fact some hospitals have problems in getting staff

physicians to dictate discharge summaries in 30 days!

Section 483.25, regarding patient activities, requires that the facility must provide for a patient activities program, appropriate to the needs and interests of each patient. I do not believe this is realistic. With the varied backgrounds of our patients, it would be impossible to achieve. It is more realistic to require a program to meet the needs and interests of the majority of the patients, followed by attempts to direct the interests of the others toward the activities provided.

In conclusion, the proposed revision of the federal regulations is, for the most part, fair and workable. There are, of course, certain problems which are not insurmountable and which can be solved with a good common sense approach and an analysis of the interaction between the state and federal regulations.

C O N C L U S I O N

In summary, we in the nursing home industry are pleased with the progress that the federal government is making in attempting to ease the regulatory burden with which we have been plagued for several years. We are grateful that you are attempting to understand the tremendous impact reduced funding will have on the long-term care providers.

We hope that your concern will filter down to the states and result in increased funding and withdrawal of useless, expensive regulations. We appreciate the opportunity you have given us today to provide input to assist you in making some very significant decisions and recommendations.

Thank you.

APPENDIX ONE

Examples of extra paperwork required by 10D-29, Florida Administrative Code, which will increase costs to nursing home providers:

1. Physician Services:

   (a) All private facilities (Medical Directors) develop all policies and procedures for a Medical Director and all attendant paperwork, including reports. See 10D-29.107(1) and (2).

   (b) Section (7) requires reasonable effort be made to get the physician to make progress reports (how do we document that we made a reasonable effort?). See 10D-29.107(7).

2. Nursing:

   (a) Written plan with policies and procedures for obtaining relief personnel. See 10D-29.108(3)(e)(4).

   (b) Written education plan for whole facility. See 10D-29.104(10) and 10D-29.108(6).

   (c) Plan and written records of preservice education for each department. See 10D-29.108(6).

   (d) Records of inservice on approximately 26 items. This not only requires paperwork, but paying consultants to teach several of the classes. See 10D-29.108(6).

   (e) Forms to mail to the physician notifying him in advance of the recommended schedule for his visits and a second form to mail when he has missed a scheduled visit. See 10D-29.107(6) and 10D29.108(3)(e)(9).

   (f) Documenting the above. Also documenting an "attempt to notify families of impending physician's visit." See 10D-28.108(3)(e)(10).

3. Plan of Care:

   (a) Medical plan of care shall be fully developed and implemented within 48 hours of an admission. See 10D-29.109(6)(a).

      (1) New paperwork includes nursing assessment at this

time. See 10D-29.109(6)(b).

(2) Written medical care plan. New paperwork. Inspectors will look for this. See 10D-29.109(6)(a).

(b) Nursing Care Plan:

Must be written. This is new and requires a different form than (a) above. See 10D-29.109(1).

(c) Comprehensive patient care plan with all the needed assessments. Several pages of paper, some of which the federal government now requires, but would be new for all private facilities. See 10D-29.109(7).

(d) Evaluation of comprehensive care plan. The following papers will be needed to prove to surveyors that:

(1) Goals achieved or not. See 10D-29.109(7)(c)1.

(2) Identify methods and approaches to care which were not successful. See 10D-29.109(7)(c)2.

(3) Determine why the methods were or were not successful. This must be done by each discipline. See 10D-29.109(7)(c)3.

4. Dietary Department:

(a) Prepare written table of organization for dietary department which describes its structure and its relationship to other sections. See 10D-29.110(3)(a).

(b) Develop and maintain plan for obtaining relief personnel and policies and directions for use. Staff education plan. See 10D-29.110(3)(b)4b.

(c) Develop, implement and maintain written dietary service objectives, standards of practice. See 10D-29.110(3)(b)4j.

(d) Prepare records of preservice education for cooks. See 10D-29.110(3)(h)1.

(e) Prepare records, etc., for inservice education of cooks. See 10D-29.110(3)(h)3.

(f) Prepare records, etc., for preservice of all other

dietary personnel. See 10D-29.110(3)(h)3.

(g) Prepare records, etc., for inservice of all other dietary personnel. See 10D-29.110(3)(h)4.

5. All social service forms and records are new for all private patient only facilities. Also the new requirements for social services just mailed out by the Office of Licensure would require additional paperwork and more cost for all facilities. See 10D-29.115.

6. Activity Department:

(a) Written table of organization. See 10D-29.116(2).

(b) Activity staff education plan. See 10D-29.116(3)(b)5 and 10D-29.116(13).

(c) Written objectives of activities program and procedures for implementation. See 10D-29.116(3)(b)6.

(d) Records of inservice training for activities employees. See 10D-29.116(13).

(e) Records of preservice training. See 10D-29.116(13).

(f) Attendance records of all volunteers. See 10D-29.116(14)(b).

(g) Records of orientation and training of volunteers. See 10D-29.116(14)(c).

(h) Documentation for planned (nursing service, appropriate qualified therapist and attending physician) therapeutic recreation activities. See 10D-29.116(9).

(i) Work assignments written and dated of activity staff. See 10D-29.116(3)(b)3.

(j) Procedures for all activities. See 10D-29.116(3)(b)8.

(k) Organization of patient's council. See 10D-29.116(12).

(l) Records of patient council meetings. See 10D-29.116(12).

7. Infection Control Committee:

(a) For all private facilities, all policies and proce-

dures and minutes of meetings are new paperwork. See 10D-29.123(2).

(b) New paperwork for all facilities. See 10D-29.123(2)(b).

(1) Written procedures for monitoring the course of infection. See 10D-29.123(3)(f)2.

(2) Written reports from nursing department monthly on status of each infection (colds, chronic bladder infections, etc.). See 10D-29.123(3)(f)3.

(3) Records that a case review of the infections was made. See 10D-29.123(3)(f)4.

8. Housekeeping:

(a) Written table of organization for housekeeping and its relationship to other departments. See 10D-29.124(1)(a).

(b) Written plan for obtaining relief personnel, policies and directions. See 10D-29.124(1)(b)3b.

(c) Written work plan for each area of the facility. See 10D-29.124(1)(b)3f.

(d) Written housekeeping plan. See 10D-29.124(1)(e).

(e) Written education plan. See 10D-124(1)(b)3g.

(f) Records of inservice education. See 10D-29.124(1)(i).

(g) Records of preservice education. See 10D-29.124(1)(f).

(h) Work assignments that are written, dated and posted. See 10D-29.124(1)(b)3d.

(i) Written plan for linen and laundry. See 10D-29.124(2)(b)1.

9. Disaster Plan:

(a) Written agreements with various groups to provide either services or supplies. See 10D-29.126(2).

10. Education plans for each department not mentioned above (maintenance, administrative, etc.). Records of inservice and preservice for the above. See 10D-29.128(2)(a)3a.

Senator HAWKINS. We appreciate so much your coming, Mr. Harris, Mr. Lane and his father and mother and Dr. Vinger. I know you are all very busy. This is just, I think, the beginning of a dialog that we can continue. It must be. We have got to do it. As I said, there has to be a better way. It is a growing problem and each of us wants to spend our remaining years in dignity. It is incumbent upon each of us to contribute that which will make our remaining years worthwhile and worthy of each day.

We really do appreciate your contributions to the record. I appreciate Secretary Schweiker's abrupt decision on the regulations. I do not know that it is a permanent decision, but I think this hearing was—I know that this hearing was—part of the reason. They needed more information upon which to base some of those regulations. We all know that we did not agree with all of the ones as they were proposed. There is something about ink on paper up there that does something to you. I might tell you, I am very familiar with the paperwork burden because in my office, which is just a little Senator's office, we are now putting most of it on microfilm. We cannot store all of that paper just in a Senator's office. I do not know the number of papers that you have to fill out, but this is a new age of electronics and microfilm. Better training and more cooperation will help. I do not think we need to bring in several army camps here as long as we remember that these people, that we continue to refer to as "these people," are our mothers and fathers and their parents. We want them to have a lovely home and lovely care. The Government is involved, as much as we do not want them involved, they are. I want them involved more effectively and more efficiently. We have to do better for every dollar we have today. I know we have the brainpower, the devotion, and the dedication to deliver better care for the dollars that we are now getting. With caring people, like those who have participated here today, we are going to prove what can be done nationwide. This is the beginning of a dialog which we will take back to the Secretary.

At this point we will include in the record additional material supplied by those who could not be present.

[The information referred to follows:]

1982 MAR 19 PM 2:28

March 17, 1982

Senator Paula Hawkins
Subcommittee on Investigations
and General Oversight
Committee on Labor and Human Resources
1327 Dirksen Senate Office Building
Washington, D.C., 20510

Dear Senator Hawkins:

Thank you very much for your prompt response to our letter of March 1. We were so gald to learn of your upcoming hearing in Florida on March 22. We would very much like to have our views included in the record. We would appreciate your including a copy of our letter to Secretary Schweiker in the record. I have enclosed a copy for that purpose.

Again, thank you for your attention on this issue and we support your action.

Sincerely,

Donna Devall

Donna Devall, Chairperson
Social Workers in Long
Term Care
6125 33rd St. N.W.
Washington, D.C. 20015

February 25, 1982

Secretary Richard Schweiker
Department of Health and Human Services
Hubert Humphrey Building
Room 615
Washington, D.C. 20201

Dear Secretary Schweiker:

The Social Workers in Long Term Care Committee (SWLTCC) of the Metro-Washington Chapter of NASW wants to express its concern about proposed changes in federal regulations affecting long term care facilities. Our committee is made up of social workers who are actively working in long term care facilities providing essential social services to residents. Our committee has long been involved in efforts to improve the quality of life for residents in long term care facilities, and we feel the proposed regulation changes would undermine and weaken the current standards.

We are especially concerned about two areas in the proposed changes: the implementation of the proposed Patient Care Management System and the Conditions of Participation. As social workers we, of course, favor on-going, comprehensive assessment of patients as outlined in the proposed Patient Care Management System (PCMS). However, as the proposal now stands it does not adequately define how this system would be established and implemented. The current proposal needs to be far more specific regarding staffing for the PCMS, training and assessment, how often and by whom. Our committee's other major area of concern is the Condition of Participation section. The current proposal deletes the requirement for social services. We feel this would be a major step backward for residents in long term care facilities. Patients and their families need the special supports provided by social services. If this condition for participation is deleted, what real possibility will there be for enforcement of scattered provisions relating to psychosocial care? We can offer you numerous, concrete examples of the need for these services.

We urge you and the Department of Health and Human Services to stop regulatory changes which would result in reduced services and lower standards for patients in long term care facilities.

Sincerely,

Donna Devall
Co-chairperson
6125 33rd Street, N.W.
Washington, D.C. 20015

Katie Maslow
Co-chairperson
8503 Rosewood Drive
Bethesda, Maryland 20814

Members of the Committee

March 19, 1982

1982 MAR 23 PM 1:15

Paula Hawkins
United States Senator, Florida
Subcommittee on Investigations and General Oversights
Committee on Labor and Human Resources
1327 Dirkson Senate Office Building
Washington, D.C. 20510

Dear Ms. Hawkins:

I do hope that the attached position statement will reach your offices in time to be a part of the congressional hearing records you proposed for March 22, in St. Petersburg, Florida.

Not only our organization but many nursing home administrators and other health care professionals are becoming more concerned that the primay objective of the HCFA Task Force was regulatory relief, rather than the quality of care to be given the elderly, ill, or disabled who are nursing home residents.

My sincere thanks for the opportunity to share my thoughts and concerns on these very important issues.

Sincerely,

Betty A. Miller

Betty A. Miller, Executive Director

BAM:js

Enclosure

Southern California Health Care 11328 Magnolia Blvd., North Hollywood, CA 91601

(213) 877-1161 (213) 760-4461

Position Statement--Proposed Regulations
for Skilled Nursing Facilities for Medicare and Medicaid

Though they have come a long way since the Social Security Act of 1965, nursing homes continue to live with an image problem and are seen by many as places where elderly persons go to die. The news media projects nursing homes as dismal, with staff unfeeling to the needs of their residents, and cases of neglect, mental and physical abuse. To the potential resident who through the years has made his/her own decisions, of his/her own choosing, this can be a traumatic future. They may not have any other alternative than nursing home care. The proposals to repeal many of the federal regulations governing the nursing home industry are at a time when many states have been forced to cut back on inspections due to less federal money to states. The proposed drafts for these regulations would repeal the following areas and could affect the quality of care and life for the country's 1.3 million nursing home residents; including 23-25 million citizens 65 or over living in the U.S.

SPECIFIC AREAS OF CONCERN REGARDING THE PROPOSED DRAFTS FOR SKILLED NURSING FACILITY CONDITIONS OF PARTICIPATION.

1. Patient's Rights regulations, although retained as a standard, have several areas which are cause for concern. In particular, residents would not receive enough protection in involuntary transfer or in the facilities' use of chemical and physical restraints. The residents "funds" regulations offer less protection then the "final" regulations published by HFCA in July 1980. They would eliminate quarterly accounting and the specific provisions stating the rights of residents to manage their own financial affairs and appears to delete the provision giving the resident a say in how their money is spent. A residents council or other form of group representation would not be required. Although the resident must be free to voice grievances and recommend changes, the provision deletes the current wording that the resident "is encouraged and assisted throughout his/her period of stay to exercise rights as a patient and as a citizen." Several important rights of individual residents could be taken away, such as the rights of residents and the community regarding access, freedom of association and freedom of expression and other rights if a resident exhibits a communication or language barrier.

2. The condition of participation for Social Services would be deleted. Residents and their families need special support to assist them in the resident's reaction to and adjustment to institutional living. Many residents suffer from depression, anxiety, withdrawal, anger and remorse in an unfamiliar, sometimes sterile (hospital model) or even hotile environment. Nursing home staff, Social Service Designees, and Activity Directors need help in learning and maintaing necessary sensitivity toward the young, elderly and disabled residents and in dealing with their human sexuality, the perplexities and complexities of aging, and coping with death and dying, and other related psycho-social problems. This special support and counseling must come under the supervision of the professional. Under these regulations, a facility would no longer be decertified because it did not meet social services requirements as a "Condition of Participation." Social Services has a special responsibility of resident advocate, networking with community resources to get various psycho-social needs met while in the facility and to develop continuity of care such as housing , income, and supportive services for the patient when discharged.

3. The Condition of Participation for Medical Direction would be deleted. The Medical Director is presently able to monitor residents medical needs and act as a liaison between residents and their attending phys-

ician, when the attending physician is not available to direct their care. The Medical Director is now also instrumental in patient care policies. Obtaining and maintaining regular high-quality health and medical care in nursing homes has been a major problem. The proposed regulations offer no tangible solution to this dilemma and would enable physicians to visit residents even less frequently than they do now.

4. The standard for Staff Training would be deleted. Some of the most serious problems in nursing homes relate to the inadequate training of all staff, particularly for aides and orderlies. Proposed regulations on July 14, 1980, would have made considerable advancements in this area. At present, many states have opted to implement a nursing assistants training program ranging from 80 hours to 150 hours with on-going in-service training. More hours would be desirable but under the proposed regulations it is not mandated and could have deleterious effect on the quality of care given to residents.

5. Although resident Activities would be kept as a condition of participation, the proposed regulatin deletes the requirement that a staff member be "delegates responsible for the program." Also, the requirements for (and definition of) a qualified consultant be deleted. The deletion of the qualifications for the Activities Director could mean that untrained workers would be placed in these positions with limited knowledge and skills to provide the wide diversity of activities needed by individual residents and resident groups.

6. In the new proposed regulations there is no longer a specific requirement for staff-to-resident ratio. A tremendous amount of responsibility and stress would be placed on the already over burdened Nursing Director in insuring enough nursing staff to provide quality care and services. The draft calls for deletion of a requirement for scheduling showing the number and types of nursing personnel on duty. Due to the common reports of staff shortages, the burden of "patient care" would be compounded on the few dedicated nursing staff who consciously maintain an optimal level of care and independence for their residents. A staff-to-resident ratio is imperative in meeting the medical and psycho-social needs of the facility.

7. The Patient Care Management System, (PCMS), although an excellent concept, would be almost impossible to implement unless specific staff requirements were made. The Task Force has proposed a separate Condition of Participation to establish "A Patient Care Management System" for skilled nursing facilities. Current plans are for this Condition to be published as a "Final Rule." Although the concept of the PCMS is excellent, it is very important to note:
   a) Current regulations require (either directly or indirectly) essentially all of the provisions laid out in this proposed system. Even though there is a new emphasis on an "interdisciplinary team" and a requirement for a "comprehensive" initial assessment, one could certainly maintain that these requirements are now implicit under current regulations.
   b) This system cannot be implemented without a "sufficient" number of well-trained, qualified staff. A primary question has to be, "How will the system be implemented and supported by the remaining proposed regulations?" What type of qualified staff are needed and on what basis? Full-time? Part-time? Consultant? Who will actually organize "the system" in the facility? Who will provide the initial and on-going training for the staff?

page 3, cont'd.

c) What kind of survey system must be developed and maintained to assure that such systems are implemented? State agency survey programs are now being cut-back substantially. How will they monitor the system? Who will be trained to review the system? What criteria will be used to assure that the system is working in a facility?

8. The proposed regulations would delete staffing requirements calling for a full-time Medical Records "supervisor" (designee) and input from a qualified medical records consultant. It would also delete that standard requiring that only physicians enter or authenticate medical records opinions that require medical judgement. The record would no longer have to be centrally located. The maintenance of resident health records is one of the most difficult problems in a facility, and, too often, this becomes the final responsibility of an already overworked Director of Nursing. How would the proposed changes help resolve this problem? It is often noted that a number of physicians do not maintain their records as they should and the staff person helps monitor the medical records adequately. The July 14, 1980 proposal included several provisions which would seem to strengthen this Condition of Participation, but were not included in this draft. For example, provisions relating to confidentiality of the medical record information, maintenance of an inventory of residents' personal effects and valuables, and the resident's written acknowledgment of receipt of patients' rights information.

9. The regulations currently specify consultation to those facilities who do not have a qualified licensed staff person in the areas of dietary, activities, medical records, occupational therapy, social services, etc. This standard would be deleted because the HFCA Task Force believes such a requirement is presumed in that the facility must provide for resident's needs. To take "for granted" the resident's needs are met without proof is a fallacy.

Other issues of concern are the:

--Deletion of requirement that a dentist participate in staff training and that a list of dentists be given to patients.
--Changes in laboratory and radiological services, transfer agreement and infection control from separate conditions to standards under governing body and management condition.
--Deletion that requires facility staff to develop patient care policies. This could be done by other professionals, as long as at least one physician and one registered nurse were included and could be reviewed less than annually.
--Deletion of the provisions requiring by-laws and personnel policies and procedures.
--Facilities could manage their drug administration procedures as they see fit, as long as the drug error rate does not exceed two percent.
--Deletion of references to a therapeutic diet manual and standards describing how food should be prepared, stored and served.
--Federal standards for staff hygiene and facility sanitation would apply only in the absence of state law or regulations.
--Deletion of the pharmacists' responsibility to supervise the daily activities of drug storage, distribution, record keeping, and the pharmaceutical services committee.
--Deletion of the standard regarding requirements that a facility must meet if it furnishes outpatient physical therapy and the deletion of qualifications for therapists.
--Deletion references to requirements for access for handicapped.

page 4, cont'd.

--Combines infection control and physical environment conditions. Deletes requirement for annual review of aseptic and isolation techniques but would require facilities to maintain a log of instances of communicable disease outbreaks.
--Deletion of specific housekeeping staffing requirements.

The Task Force for "Regulatory Reform" has indicated that it believes the current regulations exceed, inappropriately and unnecessarily, the actual intent of the federal law. Numerous State and Federal Congressional hearings over past years have not raised the issue of nursing home regulations being too strong, but are they indeed not strong enough? Because of the public's concern for the health, safety and quality of life for nursing home residents, there may be need for stronger enforcement relating to these very issues. They appear to be vague in several areas with many inconsistencies which would be difficult for everyone to understand--administrators and ownership, facility staff, residents and their families and the general public. Certainly, a thorough review is necessary before major changes are made which would dilute or weaken the Nursing Home regulations and their enforcement which should include medical geriatric specialists, gerontologists, social workers, nutritionists and those who work in the nursing home. The goal of HFCA should be holistic care for Nursing Home residents as opposed to fragmented or token care.

We address this paper to the nursing home model in lieu of the sterile hospital model so frequently perceived.

*Resident relates to patient in this paper.

WASHINGTON STATE
Health Activities Volunteer Services

1982 MAR 26 PM 12 0

The Honorable Paula Hawkins
Room 1327
Dirkson Building
Washington, D. C. 20510

March 19, 1982

My dear Senator:

We received your letter today and we are thankful that you, too are concerned about the proposedchanges and their impact on quality care. Thank you, too, for your quick response.

You asked for a statement to submit for the record and we are enclosing one entitled "Activities Directors Goal". We hope that this will be helpful to you. It is imperative that the legislature realize the importance of a QUALIFIED Activity Director in a long term care facility.

Thank you again for your concern and assistance.

Sincerely,

Peggy Marshalek a.c.c.

Peggy Marshalek
Central Washington H.A.V.S. President
Activity Coordinator/Consultant
Yakima Convalescent
818 W. Yakima Avenue
Yakima, Washington 98902

PM/kls
enc

A Non-Profit Organization for Activities Directors/Coordinators
Recreational Therapists and Volunteers

93-587 O—82——13

ACTIVITY DIRECTORS GOAL

My goal as activity director cordinator is to make each day a full-filling and rewarding experience of everyday living to our Residents at Yakima Convalescent.

To be admitted to a nursing home, should not be looked on as a final stage, but a challenge to make each day an important day in one's life.

We do this by giving our Residents something to look forward to daily such as, special activities that are meaningful and give them the feeling of independance and responsibility, also to stimulate their mind as well as their bodies.

Residents share in planning activities through Resident Council and general discussion groups. We encourage our Residents to help motivate the other more withdrawn and less active Residents within our facility. To help them take part in group socials and group interaction.

In planning a successful activity program, one must keep in mind that we are working with senior adults that have lived many years, they have much wisdom, given much to their families and to their communities. Now that their bodies are not in the physical condition they once were we must design our activity programs to consist of as many of their normal activities as we can adapt to suit their needs. We need to make their life as busy as possible and to help them feel important to their peers as well as to theirselves.

Activities need to be planned to preserve their dignity and self esteem, to give them the rights to make a choice in what activities they choose to attend. The right to attend the religion of their choice and to continue in the politics of their choice.

I feel though they no longer can live in an independant setting, they have the right to be independant and they have the right to take some risks as they would in their normal life pattern. Over protection . . endangers a persons human dignity and tends to keep that person in a less productive daily life style. The Resident will give up and start depending on staff to take care of their daily needs when they are still capable to share in their own daily care and activities.

I try and work my activity program around keeping our Residents busy doing physical and mental individual and group activities.

We offer activities such as Garden Club which consits of lectures, displays, daily study sheets and we use creative designs for use of hand and eye coordination.

We use Music Threapy for the in room non verbal withdrawn Residents. It is also very effective as a group activity. Activities such as ceramics, painting, arts and crafts and sewing are good for keeping flexible the small motor muscles. It also gives them a feeling of possessions of their own on completion of their projects. Creative Drama via picture association is used with each Resident telling a story of past life experiences.

Out of facility activities in large group setting as well as in small groups are offered several times a month.

We use the Yakima Senior Center for planned joint nursing home dances, shows, picnics and other social functions, we feel could benefit all our Residents and the community.

I feel community exposure and envolvement are essential to the total care of our nursing home Residents. If we can not go to the community then we bring the community to us. We have done this with the Rodeo, Circus, Luau, Movies and Lectures as well as chapel and missionaries. We also have had programs from the schools and preforming arts.

Our Residents are a living part of our community and we deserve the right to belong. Residents of jursing homes are a responsible and productive part of our socity and we wish to have the right to prove it.

It is the activity directors responsibility to show the community through the news media a positive look at our Residents and their daily life patterns. We want the community to know our homes are not a place to die, but a place to enjoy life to the fullest. Our news media in Yakima has done a good job in giving us good positive coverage of our Residents activities and planned events.

It is important to keep activities at a level that is not only interesting to our Residents, but interesting for the news media to share with the community.

Peggy Marshalek
Activity Coordinator
Yakima Convalescent

Florida Gulf Health Systems Agency INC.

10051 Fifth Street North, Suite 253 • St. Petersburg 33702-2296
(813) 576-7772 • Tampa 229-2082
SUNCOM 594-2225

John H. Ross, D.D.S.
President

Edward L. Perrine, MPH
Executive Director

March 24, 1982

Senator Paula Hawkins, Chairman
Subcommittee on Investigations and
General Oversight
Committee on Labor and Human Resources
1327 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Hawkins:

I was very impressed with the broad range and quality of speakers that recently addressed the Subcommittee Hearings on Long-Term Care of the Elderly held in St. Petersburg. We appreciate the strong advocacy role that you have played in assuring that the Department of Health and Human Services would reconsider the issuance of the proposed rules on nursing homes.

I am enclosing for your information two documents that were referred to in the meeting by the Speakers:

1. A Guide to Nursing Home Care in the Bay Area that points out the health systems agency role in trying to better educate the community on effective utilization of nursing homes and identifying a checklist of items to look for to assure quality.

2. The second document is the study of the nurse shortage problem in the Bay Area. The report identifies the top major areas of conflict of why nurses do not practice in nursing home settings. These five factors include low salaries, poor staffing ratios, poor fringe benefit packages, limited opportunity for professional growth, and limited opportunity for advancement. These factors are significantly different for nurses employed in hospital settings.

In addition to the Nursing Home Guide the Florida Gulf Health Systems Agency plans to develop another guide identifying the alternative programs available in the Bay Area for longterm care. The Guide would include such services as those available from Senior Citizens Centers, Meals-on-Wheels, Congregate Living Facilities, and other althernatives that might be available to prevent institutionalization of our elderly population.

On Saturday, prior to the March 22nd Hearing, the Presbyterian Health Education and Welfare Association Board of Directors met in St. Petersburg, Florida. This group represents a cross section of official ministries throughout the United States. This organization unanimously adopted a resolution regarding the proposed nursing home rules and issues relating to longterm care for the elderly. A copy of this resolution was provided to Terry who assured me it would be entered into the Hearing Record.

Again, thank you for your sincere interest and concern from your Florida constitutents who are in need of quality longterm care services.

Sincerely,

Edward L. Perrine

Edward L. Perrine
Executive Director

cc: Rodney Martin

crc

PRESBYTERIAN HEALTH EDUCATION AND WELFARE ASSOCIATION

RESOLUTION

on

PROPOSED NURSING HOME RULES AND LONG TERM CARE OF THE ELDERLY

WHEREAS care of those who cannot care for themselves is the responsibility of the whole society;

WHEREAS government is the instrument through which the society acts for the people;

WHEREAS the charitable concerns for the wellbeing of the aged and disabled is expressed by the voluntary sector, which augments the constitutionally mandated responsibility of government for the public welfare;

WHEREAS the Medicare and Medicaid programs are the means through which the government implements this responsibility for those who are aged and disabled as well as for families with dependent children who are financially unable to care for themselves;

WHEREAS the changes proposed by the Health Care Financing Administration of the Department of Health and Human Services, as conditions for participation for providers of nursing home care, effectively reinforce the negative aspects of a double standard of care for those persons who are privately supported and for those who are publicly supported;

WHEREAS the rules change recommended the removal of reimbursement for medical direction, social services, inservice training and activities, etc., will dehumanize nursing home care, making nursing homes into "warehouses for the unwanted" and "dumping grounds for the dying";

WHEREAS government regulation and reform has only recently begun to correct exploitation, abuse, and neglect of our elderly and disabled persons in America's nursing homes and was developed as a response to the congressional investigations of the nursing home scandals in 1974-76 period;

WHEREAS the proposed reduction in Medicaid funding on the order of 30% over a three-year period (1981-83) shows the callous disregard of the government toward America's poor;

WHEREAS these reductions will also diminish the capacity of states to provide for wheelchairs, dentures, eyeglasses, canes and needed drugs to maintain minimal services for aged and disabled persons;

BE IT THEREFORE RESOLVED

The Board of Directors of the Presbyterian Health Education and Welfare Association at its annual meeting held in St. Petersburg, Florida, on March 20, 1982, votes unanimously to vigorously oppose this reduction of standards for quality care for the aged, disabled and poor as proposed by the new nursing home rules, and the Presbyterian Health Education and

Welfare Association opposes any action which promotes or exacerbates a double standard which deprives the poor of basic nursing home care available to other Americans.

The Board of Directors of the Presbyterian Health Education and Welfare Association opposes any further reductions of the federal government's responsibility for providing basic health care for the nation's medically needy.

The Board of Directors of the Presbyterian Health Education and Welfare Association opposes reduction of reimbursement rates for Medicaid by the federal government.

That the officers of the Presbyterian Health Education and Welfare Association direct that this resolution be forwarded to the President of the United States, the Secretary of Health and Human Services, appropriate governmental officials and to the stated clerks of the general assemblies of the United Presbyterian Church and the Presbyterian Church of the United States, the presiding officers of the Program Agency and Mission Board of these denominations, and to all Presbyterian members of the United States Senate and House of Representatives.

That the Presbyterian Office on Aging be requested to forward this resolution to all national organizations in its network concerned with the welfare of aged and disabled members of our society.

That the officers of the Presbyterian Health Education and Welfare Association forward this resolution to all individual, judicatory and organizational members of the Presbyterian Health Education and Welfare Association, especially Presbyterian Homes for the Aging, Inc.

ENTERED INTO THE RECORD BY:

Edward L. Perrine
Member of the Board, Presbyterian Health Education and Welfare Association and Executive Director
Florida Gulf Health Systems Agency, Inc.
10051 Fifth Street North, Suite 253
St. Petersburg, Florida 33702

AT:

United States Senate
Committee on Labor and Human Resources
Subcommittee on Investigations and General Oversight
Hearings on Long Term Care of the Elderly in Florida
Senator Paula Hawkins, Chairman
St. Petersburg, Florida
March 22, 1982

FOR:

Presbyterian Health Education and Welfare Association
1268 Interchurch Center
475 Riverside Drive
New York, New York 10115
Gerald S. Wise, President

National Citizens' Coalition for
NURSING HOME REFORM

1424 Sixteenth Street, N.W.
Suite 204
Washington, D.C. 20036
202/797-8227

Freida E. Gorrecht
President

Elma L. Griesel
Executive Director

March 25, 1982

The Honorable Richard S. Schweiker
Secretary
Department of Health and Human Services
Washington, D. C. 20201

Dear Secretary Schweiker:

We commend you for reaffirming the federal government's leadership in protecting the health, safety and rights of nursing home residents. We are pleased by this demonstration of your responsiveness to widespread public concern and are relieved to have your commitment that current minimal safeguards for nursing home residents will not be relaxed.

We hope that your commitment to maintain these safeguards for residents will extend to regulations which ensure their enforcement. As you will note, in the position statement delivered to you on March 11, 39 national organizations seek your assurance that the federal government will "continue to operate, through financial support and regulatory guidance to state agencies, an effective enforcement system that ensures minimum standards of care and decency.

"Therefore, we oppose any federal proposal to weaken the enforcement system through withdrawal of federal funds used to survey nursing homes or any reduction of state survey requirements. Additionally, we oppose authorization of deemed status for certification by a private, voluntary, non-governmental, non-regulatory body, unless such body is governed by a significant number of nursing home residents or their family members, and other representatives of consumer organizations."

We are concerned that HHS will propose regulations that would allow nursing homes to operate for three years without a certification survey. Nursing homes that comply with minimal standards require regular surveillance to assure that a change in personnel, ownership, or operation does not cause a deterioration in the quality of care. Marginal homes may develop severe problems if unchecked for a long period of time. Nursing homes with serious problems do need more frequent surveillance; however, this is already allowed for in the current system, if properly funded. Further, we are in serious disagreement with proposed revisions allowing verification by phone or mail in an unspecified time frame that deficiencies have been corrected.

Finally, we urge you not to publish regulations which would allow deemed status by the Joint Commission On Accreditation of Hospitals. In its own statements, the JCAH asserts that it is not and does not wish to be an enforcement agent. To place the JCAH in an enforcement role when it does not have the capacity or the desire to function in this fashion threatens the well-being of nursing home residents who depend on strong enforcement of the regulations for their health, safety and welfare.

We praise your important reiteration of the federal role in protecting nursing home residents. We hope you will also recognize such a commitment could be meaningless unless it is supported by enforcement provisions.

NCCNHR is a national, non-profit membership organization, founded in 1975, to improve the long-term care system and the quality of life for nursing home residents.

We urge the Department to reconsider any regulatory initiatives that do not strengthen the enforcement system.

Thank you again for your attention to our concerns.

Sincerely,

Elma L. Griesel
Executive Director

cc: President Ronald Reagan
Vice-President George Bush
Senator David Pryor
Senator David Boren
Senator Rudy Boschwitz
Senator Bill Bradley
Senator Lawton Chiles
Senator William S. Cohen
Senator Jeremiah Denton
Senator Robert Dole
Senator David Durenberger
Senator Orrin G. Hatch
Senator Paula Hawkins
Senator John H. Heinz III
Senator Nancy Kassebaumm
Senator Edward M. Kennedy
Senator Charles Mathias
Senator Daniel Patrick Moynihan
Senator Charles H. Percy

Carolyne Davis, Administrator, HCFA
Paul Willging, Deputy Administrator, HCFA
Aris T. Allen, Director, HSQB-HCFA

All organizations, agencies and individuals endorsing the position statement

All 110 NCCNHR member groups and the NCCNHR Board of Directors

All State Long-Term Care Ombudsman Programs

Representative Claude Pepper
Representative Mario Biaggi
Representative Don Bonker
Representative John D. Dingell
Representative Julian Dixon
Representative Millicent Fenwick
Representative Geraldine Ferraro
Representative James Florio
Representative Barney Frank
Representative James R. Jones
Representative Mary Rose Oakar
Representative Matthew Rinaldo
Representative Stephen Solarz
Representative Henry A. Waxman
Representative James Weaver
Representative Theodore Weiss
Representative Ron Wyden

Arthur Flemming, Commissioner
U. S. Office of Civil Rights
Robert Butler, Director,
National Institute on Aging

Thomas Bell, Executive Director,
American Health Care Association
Jack McDonald, Executive Director,
National Council of Health Centers
Laurence F. Lane, Director for Public
Policy, American Association of
Homes for the Aging
John E. Affeldt, President,
Joint Commission on Accreditation
of Hospitals

DETROIT AREA AGENCY ON AGING

3110 Book Building
1249 Washington Boulevard
Detroit, Michigan 48226
(313) 961-6680

Shelton Tappes
Chairman
Alvin D. Loving, Ph.D.
Vice Chairman
Virginia L. Crowthers
Executive Director

April 16, 1982

The Honorable Paula Hawkins
United States Senate
1327 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Hawkins:

Thank you for your letter of March 16, 1982 indicating your interest in the proposed changes in federal regulations for nursing homes.

I would like to take advantage of your offer to have my comments included in the record of the Congressional hearing held on March 22, 1982 in St. Petersburg, Florida.

The Administration has stated that it is not going to revise the Conditions of Participation for Medicare and Medicaid. The DAAA supports this decision.

Yet, the Task Force on Regulatory Reform has proposed that nursing homes which are accredited by the Joint Commission on Accreditation of Hospitals (JCAH) be given "deemed status" for Medicare and Medicaid programs.

The DAAA opposes this proposal because it places inspection of nursing homes which depend primarily on public dollars for reimbursement out of the hands of state and federal agencies.

Enclosed is information prepared by the Michigan Long-Term Care Ombudsman's Office regarding the JCAH proposal. It highlights problems we envision if this proposed change is promulgated by HHS.

Please include this enclosure along with my letter in the hearing record.

Again, thank you for your attention.

Sincerely,

Shelton Tappes
Chairperson
Board of Directors

ST:jb
cc: Senator Carl Levin
Senator Donald Riegle
Enclosure

ISSUES WITH THE HHS DRAFT PROPOSED REGULATIONS

A. JCAH GENERALLY

JCAH is a private, non-profit organization with no legislative authority or responsibility to regulate nursing home facilities. It has minimal consumer representation on its board. As a regulatory surveyor, the potential for conflict of interest is great and will be difficult to prevent.

B. LACK OF ACCESSIBILITY AND ACCOUNTABILITY

JCAH has its sole office in Chicago, contrasted against regional HHS offices. Friends and relatives of nursing home patients and consumer organizations would not have the easy access to Chicago that they have to a state regulatory agency such as the Michigan Department of Public Health (MDPH). As a private, non-profit organization, neither state legislatures nor Congress has control over JCAH activities such as they do over those of HHS and MDPH. The draft states that HHS would "consult" JCAH before making changes in regulations. Again, this would provide JCAH an inside track to discourage regulations that may be good for the patient, but inconvenient in terms of the survey process.

C. TIMELINESS

Currently facilities are surveyed annually; the HHS draft proposes changing that to every three years. It gives lip service to more frequent surveys "if necessary", but leaves completely open the questions of what conditions would trigger more frequent surveys. This means, of course, that three years will be the universal minimum. JCAH does not currently field complaints. The HHS draft does not ever propose a time line to handle complaints such as the 30 days currently in effect in Michigan.

Timeliness also speaks to the issue of correcting deficiencies that JCAH identifies. At the present time, there is a mandatory re-inspection within 90 days of the original survey. The HHS draft would eliminate this requirement, replacing it with language to require a follow-up survey "when feasible". Most likely, that would remove any impetus to act quickly from the nursing home and give the home a blank check that would quickly result in few, if any, corrections being made on a timely basis. Patient care that may be questionable at the time of the original survey, could be life threatening three years later.

Associated with the failure to set guidelines for timely corrections of deficiencies is the draft's proposal that would allow follow-up surveys to be done by mail or telephone. Given the costs of travel, it is easy to picture a surveyor calling a nursing home about a serious deficiency to get a "Oh, don't worry. We took care of that the next day" reply. Only to find three years later, that not only was the deficiency not corrected, but that the impact on patients has been serious, negative and prolonged.

D. EQUIVALENCY OF STANDARDS

The HHS draft pronounces the JCAH standards "equivalent" to those of the federal government. Such a pronouncement is misguided at best. JCAH standards are vague, ambiguous and are used as guidelines for JCAH consultants, not as regulatory conditions for participating in the medicare/ medicaid programs. There are homes in Michigan which have HCAH accreditation yet the MDPH has cited them for serious deficiencies in some areas which are not even included in the JCAH standards.

The HHS draft indicates that it will solicit comments especially on the possibility of using state's licensure regulations for "deemed status" if they are "equivalent" to the federal regulations. For Michigan, this would be fine because in many instances, the Michigan regulations are better than the federal. Nationally, there would be two major problems with using state standards:

a) Few states have the tough rules and the enforcement of those rules that Michigan has. Feeling comfortable with Michigan licensure rules is one thing, feeling comfortable with Mississippi's is another.

b) Whatever standards are used, the financial ability of states to enforce them is declining. Money for enforcement is already being reduced. If the entire process is thrust back to the states, it is doubtful that many would be able to bear the full cost by themselves. With enforcement solely on the backs of states, federal funds would quickly become unavailable.

E. COST

The preliminary remarks to the HHS draft indicate cost savings of $24 million as a primary rationale for the proposed changes in the survey process. What the drafters fail to take into consideration are the additional

costs that the proposal will create. Many states, including Michigan, piggyback their survey for state licensure standards with the survey for federal conditions of participation. JCAH, which is not equipped to handle large volumes of nursing home surveys, will have to establish a new administrative mechanism to deal with the new charge at the same time the states will have to maintain theirs in order to survey for compliance with state licensure laws. JCAH has no mechanism for dealing with complaints and will have to set up a mechanism and establish a procedure for doing so. The states will also have to maintain theirs. JCAH does not have an administrative appeals process through which homes and consumers can challenge the survey agency's findings. It will have to establish one similar to those states will also have to maintain. Given the lack of competition for doing the surveys, JCAH will be relatively unchecked in the price it imposes for surveying a facility. Whatever the cost, it will be passed on to the medicaid/medicare programs. The HHS draft also seems to disregard the increased costs associated with increased staff, consultants and travel that JCAH would incur contrasted against a stable workforce already in place at the state level. When one thinks of an added layer to the bureaucracy, one usually has images of a new top layer. What the HHS draft proposes is an intermediate layer, under the state level of enforcement. The additional layer is in the private sector and may be less visible, but it will prove more costly in the long run.

F. POSTING

JCAH facilities do not now make their inspection reports available to the public. JCAH does not require it. Comments in the HHS draft indicate that the Department wants input on the possibility of requiring a facility to post the JCAH inspection report as a condition of using the accreditation for "deemed status". Should posting become a requirement, the posting would still be insufficient. The statements contained in JCAH reports are vague and are based on standards having no substance. Secondarily, it would prevent most consumers from comparing the quality of various homes, because there would be no centralized clearinghouse such as the MDPH provides now for the Field Evaluation Reports.

Senator HAWKINS. We conclude this hearing at this time. Thank you for your attention.

[Whereupon, at 2:45 p.m., the hearing was concluded.]

○